SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
Company Tracking Number:	*HCSC ET BCBSNM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBSNM*		
Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Filing at a Glance

Company: Health Care Service Corporation

Product Name: HCSC ET BCBSNM	SERFF Tr Num: CMPL-125648906	State: ArkansasLH
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 39017
Sub-TOI: H16G.001A Any Size Group - PPO	Co Tr Num: HCSC ET BCBSNM	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Nancy French	Disposition Date: 06/03/2008
	Date Submitted: 05/15/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: HCSC ET BCBSNM	Status of Filing in Domicile:
Project Number: HCSC ET BCBSNM	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 06/03/2008	
State Status Changed: 06/03/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Dear Commissioner:

Compliance Research Services is pleased to submit the enclosed forms on behalf of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). A letter of filing authorization is enclosed.

HCSC does business in various states as follows:

• Blue Cross and Blue Shield of Illinois in Illinois;

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
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Product Name:	*HCSC ET BCBSNM*		
Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

• Blue Cross and Blue Shield of Texas in Texas;
• Blue Cross and Blue Shield of Oklahoma in Oklahoma; and
• Blue Cross and Blue Shield of New Mexico in New Mexico.

HCSC provides group medical insurance to New Mexico employers that have employees located in many states. This filing is for HCSC's New Mexico division however, we will be submitting similar filings for the other divisions of the company.

We are also sending hard copies of these forms to you by mail as you requested in November of 2007.

Note that the Arkansas Rider, Form ETGB-AR-HCSC-07 was previously submitted and is currently being reviewed under SERFF Tracking number CMPL-125619854. The rider will be used with the Certificate submitted with that filing as well as the above noted Certificate.

Submitted Materials. The coverage in question is true group coverage sold in New Mexico by licensed New Mexico agents and brokers.

The provisions of the certificate may change according to the benefits negotiated between the employer and HCSC. The enclosed certificate includes provisions for participating provider hospitals and physicians. Coverage may also be issued on a fee for service basis without the network provisions. Individuals insured under network plans have access to their local Blue Cross provider networks under the national Blue Cross association BlueCard plan. The rider has been drafted to bring the certificate into compliance with applicable Arkansas requirements.

Provisions in the certificate that may vary from employer to employer are bracketed. HCSC requests the right to change the type style and paper size or to issue the forms in electronic format.

The forms have been tested for readability. Certification of readability is enclosed.

If you have any questions or comments, please call me at 513-894-6050 or by email at dsimon@crssolutionsgroup.com.

Thank you for your assistance in this matter.

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Product Name:	*HCSC ET BCBSNM*		
Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Sincerely,

J. David Simon, CLU
President
Phone: 513.984.6050
Fax: 513.984.7212
E-Mail Address: dsimon@crssolutionsgroup.com

Company and Contact

Filing Contact Information

(This filing was made by a third party - complianceresearchservicesllc)

Nancy French, Product Manager
10921 Reed Hartman Highway
Cincinnati, OH 45242

nfrench@crssolutionsgroup.com
(513) 984-6050 [Phone]
(513) 984-7212[FAX]

Filing Company Information

Health Care Service Corporation
300 East Randolph Street
Chicago, IL 60601
(513) 984-6050 ext. [Phone]

CoCode: 70670
Group Code: 917
Group Name:
FEIN Number: 36-1236610

State of Domicile: Illinois
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
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Per Company: No

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Health Care Service Corporation	$50.00	05/15/2008	20344071

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
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Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/03/2008	06/03/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	05/16/2008	05/16/2008	Nancy French	05/28/2008	05/28/2008

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
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Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Disposition

Disposition Date: 06/03/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
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Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization	Approved-Closed	Yes
Supporting Document	Readability	Approved-Closed	Yes
Supporting Document	Certification of Benefit Differential	Approved-Closed	Yes
Form *(revised)*	Rider	Approved-Closed	Yes
Form	Rider	Withdrawn	No
Form	Certificate	Approved-Closed	Yes

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
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Product Name:	*HCSC ET BCBSNM*		
Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/16/2008
Submitted Date	05/16/2008
Respond By Date	

Dear Nancy French,

This will acknowledge receipt of the captioned filing.

Objection 1

- Rider (Form)

Comment: The rider for Arkansas residents must contain the following:

1. There must be a conversion privilege that complies with ACA 23-86-115.
2. Under the providers, please add Nurse Anesthetists as required by ACA 23-79-114(f).
3. Please certify that benefits payable a PPO and Non-PPO will comply with our Bulletin 9-85. There can be no more than a 25% differential in payment of benefits between a PPO and Non-PPO.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/28/2008
Submitted Date	05/28/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Dear Ms. Minor:

The following is in response to your May 15, 2008 objection:

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
Company Tracking Number:	*HCSC ET BCBSNM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBSNM*		
Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

1. The Conversion provision has been added to the Rider where it has been revised to remove the requirement that the insured be covered for at least 3 months under the Group policy in order to convert coverage, to comply with ACA 23-86-115. Additionally, the provision has been reworded slightly to be consistent with other terminology in the Certificate.

2. The provision shown in the Rider addressing Providers has been revised to add Nurse Anesthetists as required by ACA 23-79-114(f).

3. Enclosed is certification that there will be no more than a 25% differential in payment of benefits between a PPO and NON-PPO provider..

Related Objection 1

Applies To:

- Rider (Form)

Comment:

The rider for Arkansas residents must contain the following:

1. There must be a conversion privilege that complies with ACA 23-86-115.
2. Under the providers, please add Nurse Anesthetists as required by ACA 23-79-114(f).
3. Please certify that benefits payable a PPO and Non-PPO will comply with our Bulletin 9-85. There can be no more than a 25% differential in payment of benefits between a PPO and Non-PPO.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Certification of Benefit Differential

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Rider	ETGB-AR-HCSC-07		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		42	HCSC Arkansas ET Rider_rev 051608.pdf

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
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Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Previous Version

Rider	*ETGB-AR-HCSC-07*	*Certificate Amendment, Initial Insert Page, Endorsement or Rider*	*42*	HCSC Arkansas ET Rider_rev 080907.pdf

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
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Product Name:	*HCSC ET BCBSNM*		
Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

No Rate/Rule Schedule items changed.

Sincerely,
Nancy French

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
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Form Schedule

Lead Form Number: GB-10-1 HCSC

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	ETGB-AR-HCSC-07	Certificate Amendment, Insert Page, Endorsement or Rider	Rider	Initial		42	HCSC Arkansas ET Rider_rev051608.pdf
Approved-Closed	GB-NM-LT-1 HCSC	Certificate	Certificate	Initial		40	New Mexico BCBS Master Certificate.pdf

RIDER FOR RESIDENTS OF THE STATE OF ARKANSAS

If you reside permanently in the state of Arkansas, the [Certificate][Benefit Booklet] to which this Rider is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the [Certificate][Benefit Booklet] and this Rider, the provisions resulting in greater [benefits][Benefits] will be in effect.

1. **Individual and Family Eligibility**

   The eligibility provision outlining a change in coverage from [individual coverage][Individual Coverage][Single Coverage] to [family coverage][Family Coverage] is changed as follows:

   If you apply for a change from [individual coverage][Individual Coverage][Single Coverage] to [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], your [family coverage][Family Coverage] will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply for [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], you can make application at any time. Your [dependents][Dependents] will be subject to the [preexisting condition waiting period][Preexisting Condition Waiting Period] outlined in the [Certificate][Benefit Booklet] to which this Rider is attached. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

2. **Family Coverage**

   The eligibility provision concerning adding [dependents][Dependents] to [family coverage][Family Coverage] is changed as follows**:**

   If you apply to add your newborn [child][Child] to your [family coverage][Family Coverage] within 90 days of the [child's][Child's] birth or to add your adopted [child][Child] or [child][Child] placed for adoption to your [family coverage][Family Coverage] within 60 days of the adoption or [placement for adoption][Placement for Adoption], coverage for your [dependent][Dependent]will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply to add your newborn within 90 days of the birth, or your adopted [child][Child] within 60 days of the adoption or [placement for adoption][Placement for Adoption], you can make application at any time. Your [dependents][Dependents]will be subject to the [preexisting

condition waiting period][Preexisting Condition Waiting Period] outlined in the [Certificate][Benefit Booklet] to which this Rider is attached. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

3. Providers

Benefits for the following Providers will be paid at the same level as other Providers.

- [Advanced practice nurses][Advanced Practice Nurses].
- Athletic trainers.
- [Audiologists][Licensed Audiologists].
- Certified orthotists.
- [Chiropractors][Doctors of Chiropractic].
- Community mental health centers or clinics.
- [Dentists][Doctors of Dentistry]
- [Coordinated Home Care][Home Health Care][home health care].
- Hospice care.
- Hospital–based service.
- Hospitals.
- Licensed ambulatory surgery centers.
- Licensed [social workers][Clinical Social Workers].
- Licensed [dieticians][Dieticians].
- Licensed [professional counselors][Professional Counselors].
- Licensed psychological examiners.
- Long–term care facilities
- Nurse Anesthetists
- [Occupational therapists][Licensed Occupational Therapists][Occupational Therapists].
- Optometrists.
- Pharmacists.
- [Physical therapists][Licensed Physical Therapists][Physical Therapists].

- Physicians and surgeons (M.D. and D.O.).
- [Podiatrists][Doctors of Podiatry].
- Prostheticists.
- [Psychologists][Doctors of Psychology].
- Respiratory therapists.
- Rural health clinics; and
- [Speech pathologists][Licensed Speech–Language Pathologists].

4. [Speech Therapy

The [speech therapy][Speech Therapy] benefit is revised to delete the [Benefit Period][benefit period] maximum.]

5. Well Child Care

Benefits will be provided for [Eligible Expenses][Eligible Charges][Covered Charges][Allowable Charge] rendered by a Physician to [children][Children] under age 19, even though they are not ill. Benefits will be limited to the following services:

- Immunizations;
- Routine diagnostic tests;
- 20 physical examinations at approximately the following age intervals:
    - Birth,
    - Two weeks,
    - Two months,
    - Four months,
    - Six months,
    - Nine months,
    - 12 months,
    - 15 months,
    - 18 months,
    - Two years,
    - Three years,
    - Four years,
    - Five years,

- Six years,
- Eight years,
- 10 years,
- 12 years,
- 14 years,
- 16 years, and
- 18 years.

Benefits for immunizations will not be subject to any [copayment][Copayment], [deductible][Deductible], [coinsurance][Coinsurance] or [benefit period][Benefit Period] dollar maximum.

6. Phenylketonuria Treatment

Benefits will be provided for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed by a Physician for the therapeutic treatment of phenylketonuria.

7. Musculoskeletal Disorders

Benefits will be provided for the surgical and non–surgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head including [Temporomandibular Joint Dysfunction][temporomandibular joint disorder][Temporomandibular Joint Syndrome][temporomandibular joint dysfunction] and craniomandibular disorder. Your [benefits][Benefits] for musculoskeletal disorders are the same as your [benefits][Benefits] for any other condition.

8. Speech and Hearing

Benefits will be provided for the treatment of loss or impairment of speech or hearing by a speech pathologist or audiologist subject to the same limits, [deductibles][Deductibles] and [coinsurance][Coinsurance] as other [covered services][Covered Services].

9. In Vitro Fertilization

Benefits will be provided for in vitro fertilization procedures for you or your [dependent][Dependent] spouse when:

- Your or your spouse's oocytes are fertilized with the sperm of you or your spouse, and
- You or your spouse have a history of unexplained infertility of at least two years duration; or
- The infertility is associated with one or more of the following medical conditions:

- Endometriosis;
- Exposure in utero to diethylstilbestrol, commonly known as DES;
- Blockage of or removal of one or both fallopian tubes that is not a result of voluntary sterilization; or
- Abnormal male factors contributing to the infertility.

- The in vitro fertilization procedures are performed at a [facility][Facility] licensed or certified by the Arkansas Department of Health which conforms to the standards of the American College of Obstetricians and Gynecologists', or are performed at a [facility][Facility] certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
- You or your spouse has been unable to obtain successful pregnancy through any less costly infertility treatment for which coverage is available under the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan].

The [benefits][Benefits] for in vitro fertilization are the same as the [benefits][Benefits] provided under maternity benefit provisions. Cryopreservation, the procedure whereby embryos are frozen for late implantation, is included as an in vitro fertilization procedure.

10. Maternity Care

The coverage for [Maternity Services][Maternity Care][maternity care] is changed to allow [routine nursery care][Routine Nursery Care] and pediatric charges for a well newborn [child][Child] for up to five full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth.

11. Cancer Treatment

Benefits will be provided for drugs used for the treatment of cancer if:

- The drug has been approved by the federal Food and Drug Administration for the treatment of the specific type of cancer for which it has been prescribed; and
- The drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.

12. Mammograms

Benefits will be provided for mammograms as follows:

- A base line mammogram for a female who is at least thirty–five years of age but less than forty years of age;

- One mammogram every one to two years for a female who is from 40 to 49 years of age; and
- One mammogram a year for a female who is at least fifty years of age; or
- A mammogram upon recommendation of a woman's Physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer.

13. Colorectal Cancer

Benefits will be provided for colorectal cancer examinations as follows:

- If you are more than 50 years of age;
- If you are age 50 and under and are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines; or
- If you are experiencing bleeding from the rectum or blood in the stool, or if you have a change in bowel habits such as diarrhea, constipation or narrowing of the stool that lasts for more than five days.

14. Anesthesia and Dental Procedures

Benefits will be provided for anesthesia, [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] charges for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the patient is:

- A [child][Child] under seven years of age who is determined by two licensed [dentists][Dentists] to require without delay necessary dental treatment in a [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] for a significantly complex dental condition;
- A person with a diagnosed serious physical condition or [Mental Illness][Mental Health Care disorder][Mental Health Disorder]; or
- A person with a significant behavioral problem as determined by the [member's][Member's] Physician.

Immunizations are exempt from any [copayment][Copayment], [coinsurance][Coinsurance], deductible[Deductible] or dollar limit.

15. [Mental Illness][Mental Health Care][Mental Health] and [Substance Abuse Rehabilitation][Chemical Dependency][Drug Abuse and Alcoholism]

The benefit maximums for the [inpatient][Inpatient] and [outpatient][Outpatient] treatment of [Mental Illness][Mental Health Care][Mental Health Disorders] do not apply.

Your [benefits][Benefits] for [inpatient][Inpatient] and [outpatient][Outpatient] [Substance Abuse Rehabilitation][treatment of Chemical Dependency][treatment of drug abuse and alcoholism] are limited to a combined maximum of $6,000 each 24 month period. No more than $3,000 shall be provided in any 30 consecutive day period.

A combined lifetime maximum of $12,000 will apply to [benefits][Benefits] for [inpatient][Inpatient] and [outpatient][Outpatient] [Substance Abuse Rehabilitation][treatment of Chemical Dependency][treatment of drug abuse and alcoholism].

16. Late Claim Payments

The interest rate for a [claim][Claim] not paid on time by the claim administrator is 12%.

17. Continuation of Coverage

If you have been insured continuously under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] for at least three months and your coverage has been terminated for any reason other than nonpayment of the required contribution, you may continue coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] for an additional three months. You must request continuation in writing no later than 10 days after the termination of employment or membership or a change in marital status. You must pay the entire premium including any portion paid by your former [employer][Employer]. Continuation of coverage is subject to the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] or a successor [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] remaining in force.

Continuation of coverage shall end at the earliest of the following dates:

- 120 days after continuation of coverage begins;
- The end of the period for which the individual made a timely contribution;
- The contribution due date following the date the individual becomes eligible for Medicare; or
- The date on which the [policy][contract] is terminated or the [group][Group] withdraws from the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan].[

18. Conversion Privilege

If your coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] should terminate for any reason, including the discontinuance of the [group policy][Group Policy] in its entirety, and you want to continue [Blue Cross and Blue

Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] coverage with no interruption, you may do so if your [Employer][Group] has not cancelled this coverage and replaced it with other coverage. Here is what to do:

1. Tell [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] or your group administrator that you wish to continue your coverage and you will be provided with the necessary application.
2. Send the application and first premium to [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] within 31 days of the date you leave your [Employer][Group] or within 15 days after you have been given written notice of the conversion privilege, but in no event later than 60 days after you leave your [Employer][Group].

Having done so, you will then be covered by [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] on an individual "direct pay" basis. This coverage will be effective from the date your coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] terminates so long as the premiums charged for the direct pay coverage are paid when due.

These direct pay benefits (and the premium charged for them) may not be exactly the same as the benefits under the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan]. However, by converting your coverage, your benefits under the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] are not interrupted and you will not have to repeat waiting periods (if any).

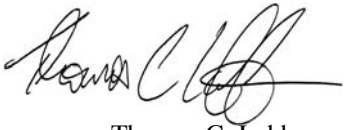
[Should any or all of your [dependents][Dependents] become ineligible for coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan], they may convert to direct pay coverage by following the instructions stated above.]]

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the [Certificate][Benefit Booklet] to which this Rider is attached will remain in full force and effect.

[Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)
(Blue Cross and Blue Shield of Texas)
(Blue Cross and Blue Shield of New Mexico)
(Blue Cross and Blue Shield of Oklahoma)

Raymond F. McCaskey
President



Thomas C. Lubben
Secretary]

A message from

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

This health care benefit program is underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM), your partner in health care. Like most people, you probably have many questions about your coverage. This Benefit Booklet contains a great deal of information about the services and supplies for which benefits will be provided under your benefit program. Please read your entire Benefit Booklet very carefully. We hope that most of the questions you have about your coverage will be answered.

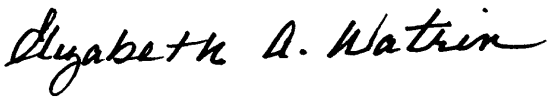
In this Benefit Booklet we refer to our company as ''BCBSNM'' and we refer to the company or association that you work for as the ''Group.'' The *Definitions* section will explain the meaning of many of the terms used in this Benefit Booklet. All terms used in this Benefit Booklet, when defined in the *Definitions* section, begin with a capital letter. Whenever the term ''you'' or ''your'' is used, we also mean all eligible family members who are covered under this benefit program.

BCBSNM and your Group may change the benefits described in this Benefit Booklet. If that happens, BCBSNM or your Group will notify you of those mutually agreed upon changes.

If you have any questions once you have read this Benefit Booklet, talk to your Group Administrator or call us at the number listed on the back of your ID Card or as listed in *Customer Assistance*. It is important to all of us that you understand the protection this coverage gives you.

Welcome to Blue Cross and Blue Shield of New Mexico! We are very happy to have you as a Member and pledge you our best service.

Sincerely,



Elizabeth A. Watrin
President
Blue Cross and Blue Shield of New Mexico

CUSTOMER ASSISTANCE

For Medical/Surgical Claims[and Prescription Drugs]—When you have questions or concerns, call BCBSNM Monday through Friday from [6 a.m. – 10 p.m.] and [8 a.m. – 5 p.m.] on weekends and holidays or visit the BCBSNM Customer Service department in Albuquerque. (If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service representative will return your call by [5:00 p.m.] the next business day.) You may either call toll-free or visit the BCBSNM office in Albuquerque at:

Street address: [4373 Alexander Blvd. NE]
Toll-free telephone number: [1-800-432-0750]

Send all **written inquiries/Prior Approval requests** and submit **medical/surgical claims*** to:

[Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, NM 87125-7630]

[[Admission Review and Other Prior Approvals][Prior Approvals: Medical/Surgical Services[and Prescription Drugs]]—For admission review, including medical/surgical services[, Mental Health and Chemical Dependency] and other Prior Approval requests, call a Health Services representative, Monday through Friday, between [8 a.m. and 5 p.m.], Mountain Time. Written requests should be sent to the address given above. **Note:** If you need Prior Approval assistance between [5 p.m. and 8 a.m.] or on weekends, call Customer Service. If you call after normal Customer Service hours, you will be asked to leave a message.

[(505) 291–3585 or 1-800-325-8334]]

[Mental Health and Chemical Dependency—For inquiries or Prior Approvals related to Mental Health or Chemical Dependency services call, the BCBSNM Behavioral Health Services Administrator:

[24 hours/day, 7 days/week:]

[1-800-583-6372 or 1-505-816-6790]

Send claims* to:

[Claims, Mesa Mental Health
P.O. Box 92165
Albuquerque, New Mexico 87199-2165]

All other correspondence:

[Mesa Mental Health
P.O. Box 90607
Albuquerque, New Mexico 87199-0607]]

[Web site—For Provider network information, [BCBSNM Drug List,]claim forms and other information or to e-mail your question to BCBSNM, visit the BCBSNM Web site at:

[www.bcbsnm.com]]

***Exceptions to Claims Submission Procedures**—Claims for health care services received [outside New Mexico]from Providers that do not contract **directly** with BCBSNM[(or Mesa Mental Health)], should be sent to the Blue Cross Blue Shield Plan in the state where services were received. [**Note: Do not submit drug plan claims to BCBSNM. The name and address of the pharmacy benefit manager is in a separate brochure.**]See *Claim Payments and Appeals* for details on submitting claims.

Be sure to read this Benefit Booklet carefully and refer to the Benefit Highlights.

TABLE OF CONTENTS

BENEFIT HIGHLIGHTS

This is only a summary that lists the Deductible, Out-of-Pocket Limit, and Member Coinsurance and Copayment amounts and provides a brief description of [Name of Plan] benefits.

[Name of Plan] benefit program benefits[: This benefit program does **not** cover services received from Nonpreferred Providers, except in an Emergency.]	**Member's Share of Covered Charges**	
	Preferred Provider	**Nonpreferred Provider**
Lifetime Maximum: There is no lifetime maximum benefit. However, certain services may have Benefit Period maximums. See below.		
Lifetime Maximum	$[250,000–10,000,000]	
Benefit Period Deductible		
Individual Deductible	$[100–25,000]	
Family Deductible	$[100–25,000]	
Benefit Period Deductible [(per individual) Deductible amount is listed on your ID Card. Family Deductible is aggregate of three times individual amount.][(except for diagnostic lab and x-ray which are not subject to the Deductible –– only Covered Charges for services subject to a percentage (Coinsurance) amount apply toward the Deductible)]	[$[100–25,000]] [($[100–25,000] family)][$[100–25,000][($[100–25,000]] family)][Not Applicable]	[$[100–25,000]][($[100–25,000] family)][$[100–25,000]] [($[100–25,000] family)][Not Applicable]
Individual Coverage: Benefit Period Deductible – Deductible amount is listed on your ID Card.	$[100–25,000]	
Family Coverage: Benefit Period Deductible – Deductible amount is listed on your ID Card. No individual deductible.	$[100–25,000]	
Out-of-Pocket Limit [(Includes Coinsurance only, NOT Deductible, penalty amounts or noncovered charges.)][Coinsurance and Copayments only apply; Deductible, penalty amounts and noncovered charges do not.][Copayments and Preferred Provider Coinsurance amounts apply to Preferred Provider limit. Nonpreferred Provider Coinsurance only applies to Nonpreferred Provider Limit. No family Out-of-Pocket Limit is available.]	[$[100–25,000]][($[100–25,000] family)][$[100–25,000][($[100–25,000]family)][Not Applicable]	[$[100–25,000]][($[100–25,000] family)][Not Applicable][$[100–25,000]]
Out-of-Pocket Limit (Includes Deductible, Copayments, and Coinsurance amounts only, NOT penalty amounts or noncovered charges.)	$[100–25,000] [($[100–25,000] family)]	
PPO Primary Provider (PPP) Office Visit/Examinations Copayment (including Physicals): All other services received during the office visit to the PPP are subject to Deductible and Coinsurance as listed below.	$[5–100] per visit[Deductible waived]	Not Covered
Other Office Services: Includes all other services received during a PPP office visit and services of non-PPP Providers (including routine examinations and physicals).	10–50]%	10–50]%
Non-PPP Office Visit	10–50]%	10–50]%

[Name of Plan] benefit program benefits[: This benefit program does **not** cover services received from Nonpreferred Providers, except in an Emergency.]	**Member's Share of Covered Charges**	
	Preferred Provider	**Nonpreferred Provider**
Office Surgery (including casts, splints and dressings)	10–50]%	10–50]%
Lab Tests, X-Rays, EKGs, Other Diagnostic Tests	10–50]%	10–50]%
Immunizations, Allergy Injections, Tests Serum	10–50]%	10–50]%
Routine Vision or Hearing Screenings (only through age 17)	10–50]%	10–50]%
Primary Provider Services:	$[5–100] per visit	Not Covered
Office Visit, Medication Management	$[5–100] per visit	Not Covered
Office Surgery (including casts, splints and dressings)	$[5–1,000] per visit	Not Covered
Preventive Care (Adult medical care/routine examinations; well child care; vision/hearing screening for Members age 17 and under)	$[5–100] per visit	Not Covered
Specialty Physician Services:	$[5–100] per visit	Not Covered
Office Visit, Medication Management, Office Evaluations	$[5–100] per visit	Not Covered
Office Surgery (including casts, splints and dressings)	$[5–100] per visit	Not Covered
Lab Tests, X-Rays, EKGs, MRIs & Other Diagnostic Services (including tests done in office, Outpatient Facility, freestanding facility, ambulatory surgery facility or any other place of treatment)	10–50]%[No Deductible]	Not Covered
Copayments and Coinsurance		
Inpatient Hospital/Facility Copayment	$[100–5,000] per admission	10–50]%
Emergency Room/Outpatient Facility Copayment	$[5–1,000] per visit	10–50]%
Office Services (nonroutine/nonpreventive)		
Office Visit	$[5–100] per visit	10–50]%
Office Surgery (including casts, splints and dressings)	$[5–1,000] per visit	10–50]%
Lab Tests, X-rays, EKGs, Other Diagnostic Tests	No Copayment	10–50]%
Allergy Injections, Tests and Serums	10–50]%	Not Covered
Office Services (nonroutine/nonpreventive)		
Office Visit	[10–50]%][$[5–100] per visit]	[10–50]%][$[5–100] per visit]
Office Surgery (including casts, splints and dressings)	[10–50]%][$[5–1,000] per visit]	[10–50]%] [$[5–1,000] per visit]

[Name of Plan] benefit program benefits[: This benefit program does **not** cover services received from Nonpreferred Providers, except in an Emergency.]	**Member's Share of Covered Charges**	
	Preferred Provider	**Nonpreferred Provider**
Lab Tests, X-rays, EKGs, Other Diagnostic Tests	[10–50]%] [$[5–100]]	[10–50]%][$[5–1,000]]
Allergy Injections, Tests and Serums	[10–50]%][$[5–100]]	[10–50]%][$[5–100]]
Routine/Preventive Services Adult Physicals and Gynecological Examinations ages 18 and older), Related Testing (includes routine Pap tests, mammograms, colonoscopy, cholesterol tests, urinalysis, etc.) and immunizations	[Plan pays [50–100]% (no Deductible) for first $[100–500] in Covered Charges; thereafter services are subject to Deductible and Coinsurance][$[5–100] per visit][(no Copayment for services other than examination][10–50]%]	[Not Covered][10–50]%]
Well-Child Care; Routine Vision or Hearing Screenings (only through age 17); Routine Testing and immunizations	[Plan pays 100% (no Deductible)][$[5–100] per visit][(no Copayment for services other than examination)]10–50] %	[10–50]%][Not Covered][**(limited to $**[100–5,000] **per Benefit Period)**]
Acupuncture Treatment (max. $[100–20,000]**/Benefit Period)**	[10–50]%][$[5–100]per visit]	[10–50]%][$[5–100] per visit][Not Covered]
Allergy Services (testing and injections)		
Primary Provider	$[5–100] per visit	Not Covered
Specialist	$[5–100] per visit	Not Covered
Allergy Serum	10–50]%	
Ambulance Services: Ground and Emergency Air Transport	[10–50]%][$[10–500] per trip][waived if admitted or between Facilities]	
Ambulance Services: Nonemergency Air Transport	[10–50]%][$[10–500] per trip]	[10–50]%]$[10–500] per trip
Ambulance Services	$[10–500] per trip/ground or $[10–500] per trip/air	
Cardiac and Pulmonary Rehabilitation, Outpatient	[10–50]%][$[5–100] per visit]	[10–50]%][$[5–100] per visit][Not Covered]
Dental/Facial Accidents, Oral Surgery and TMJ/CMJ Services	10–50]%	[10–50]%][Not Covered]
Dental/Facial Accidents, Oral Surgery and TMJ/CMJ Services		
Office Visit Copayment	$[5–100] per visit	[10–50]%][Not Covered]
Inpatient Hospital/Facility Copayment	[10–50]%][$[100–5,000] per admission]	[10–50]%][Not Covered]
Emergency Room/Outpatient Facility Copayment	$[5–1,000] per visit	[10–50]%][Not Covered]
Emergency Room Treatment and Urgent Care Facility	[10–50]%][$[5–1,000] per visit]	[10–50]%][$[5–1,000] per visit]

[Name of Plan] benefit program benefits[: This benefit program does **not** cover services received from Nonpreferred Providers, except in an Emergency.]	**Member's Share of Covered Charges**	
	Preferred Provider	**Nonpreferred Provider**
Emergency Room/Emergency Observation Treatment	[10–50]%][$[5–1,000] per visit]	
Emergency and Urgent Care Services		
Emergency Room (includes all related ER services)	$[5–1,000] per visit	Not Covered
Observation Room (including pregnancy)	$[5–1,000] per visit	Not Covered
Urgent Care Facility	$[5–1,000] per visit	Not Covered
Home Health Care/Home I.V. Services[**(prescribed home nursing care, physician and therapy care)**][(max. [100–365] visits/Benefit Period)]	[10–50]%][$[5–1,000] per visit]	[10–50]%][$[5–100] per visit][Not Covered]
Hospice Services[(lifetime max. **$**[100–20,000])]	[10–50]%][No Copayment]	10–50]%
Hospice Services - Inpatient	10–50]%	
Hospice Services - home	No Charge	
Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and Skilled Nursing Facility Admissions. See "Psychotherapeutic Services" for Inpatient treatments related to Mental Health or Chemical Dependency. See "Transplant Services," if applicable.)		
Inpatient Medical/Surgical and **Maternity-Related** Room and Board and **Covered Ancillaries**	[10–50]%][$[100–5,000] per admission][(no charge for Physician)]	[10–50]%][$[100–5,000] per admission]
Routine Inpatient Nursery Care for Covered Newborns	[10–50]%][No Copayments if mother is covered]	10–50]%
Outpatient/Ambulatory Surgical Center Treatment, including therapies and surgical procedures	[10–50]%][$[5–1,000] per visit][(no charge for Physician)]	10–50]%
Room and Board and Physician Care such as Physician Visits, Surgeon and Anesthesiologist, Lab, X-Ray and other Diagnostic Tests	10–50]%	Not Covered
Maternity - initial visit to diagnose pregnancy	$[5–100]	Not Covered
Maternity - prenatal & post delivery examinations, Inpatient delivery	10–50]%	Not Covered
Newborn Care - must be enrolled **within 31** days of birth	10–50]%	Not Covered
Lab, X-Ray and Other Diagnostic Tests	[10–50]%][No Deductible][No Copayment]	[10–50]%][Not Covered]
Maternity Services, including Routine Inpatient Pediatrician Care for Covered Newborn (also see "Inpatient Hospital/Facility Services")	[10–50]%][(plus $[5–100] for first office visit if to a PPP)]	10–50]%
Maternity Services including Routine Inpatient Pediatrician Care for Covered Newborns (also see "Inpatient Hospital/Facility Services")		

[Name of Plan] benefit program benefits[: This benefit program does **not** cover services received from Nonpreferred Providers, except in an Emergency.]	**Member's Share of Covered Charges**	
	Preferred Provider	**Nonpreferred Provider**
Office Visit Copayment	$[5–100] per visit	10–50]%
Inpatient Hospital/Facility Copayment	$[100–5,000] per admission	10–50]%
Emergency Room/Outpatient Facility Copayment	$[5–1,000] per visit	10–50]%
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods & Smoking/Tobacco Cessation	See your separately issued Prescription Drug Plan Rider	
Prosthetics and Orthotics[(equipment and supplies over $500[100–5,000] require Prior Approval)]	[10–50]%][**(Unlimited benefit)][(limited to $[100–20,000] per Benefit Period)]**	[10–50]%][Not Covered][**(limited to $[100–20,000] per Benefit Period)]**
Psychotherapeutic Services, Inpatient and Outpatient (Includes Mental Health services and Chemical Dependency rehabilitation[; maximum benefit of up to [30–365] **days** per Benefit Period for Inpatient Services][; maximum benefit of up to **$**[3,500–30,000] per Benefit Period for Outpatient Services]. Chemical Dependency also limited to services received within a maximum of **2, 12-month benefit periods**.)[Administered by BCBSNM]	[10–50]%][$[5–100] per visit]	[10–50]%][Not Covered]
Psychotherapeutic Services, Inpatient and Outpatient (Includes Mental Health services and Chemical Dependency rehabilitation; maximum benefit of up to **$**[3,500–30,000] per Benefit Period for outpatient services and [30–365] **days** per Benefit Period for Inpatient Services. Prior authorization is required. Chemical Dependency also limited to services received within a maximum of **2, 12 month benefit periods**.)		
Office Visit Copayment	$[5–100] per visit	Not Covered
Inpatient Hospital/Facility Copayment	$[100–5,000] per admission	Not Covered
Emergency Room/Outpatient Facility Copayment	$[5–100] per visit	Not Covered
Psychotherapy: Mental Health		
Inpatient Rehabilitation (max. [30–365] **days** per Benefit Period)	10–50]%	[10–50]%][Not Covered]
Outpatient/Office Rehabilitation (limit **$**[3,500–30,000] per Benefit Period)	10–50]%	[10–50]%][Not Covered]
Chemical Dependency (Alcoholism/Drug Abuse): Limited to services received during **2, 12-month benefit periods**.		
Inpatient Rehabilitation (max. [30–365] **days** per Benefit Period)	10–50]%	[10–50]%][Not Covered]
Outpatient/Office Rehabilitation (limit **$**[3,500–30,000] per Benefit Period)	10–50]%	[10–50]%][Not Covered]

[Name of Plan] benefit program benefits[: This benefit program does **not** cover services received from Nonpreferred Providers, except in an Emergency.]	**Member's Share of Covered Charges**	
	Preferred Provider	**Nonpreferred Provider**
Short-Term Rehabilitation, Inpatient and Outpatient: Occupational, Physical and Speech Therapy[**; spinal manipulations;**] including Physical Rehabilitation and Skilled Nursing Facility[; maximum benefit of up to [5–365] **days**/Benefit Period for Inpatient Rehabilitation][; maximum benefit of up to **$**[3,500–30,000]/Benefit Period for Outpatient and Office Rehabilitation]		
Inpatient Rehabilitation	[10–50]%][$[100–5,000] per admission]	[10–50]%][Not Covered]
Outpatient and Office Rehabilitation	[10–50]%][$[5–100] per visit]	[10–50]%][Not Covered]
Office Visit Copayment	$[5–100] per visit	[10–50]%][Not Covered]
Inpatient Hospital/Facility Copayment	$[100–5,000] per admission	[10–50]%][Not Covered]
Emergency Room/Outpatient Facility Copayment	$[5–1,000] per visit	[10–50]%][Not Covered]
Smoking/Tobacco Cessation Counseling (**90 minutes total** or **2 group sessions** per Benefit Period)	[10–50]%][$[5–100] per visit]	[10–50]%][Not Covered]
Spinal Manipulation Services[**(max.** [**$**[100–20,000]][[5–365] **visits**]**/Benefit Period)**]	[10–50]%][$[5–100] per visit]	[10–50]%][Not Covered]
Supplies and Durable Medical Equipment[**(equipment and supplies over $500**[100–5,000] **require Prior Approval)**]	[10–50]%][$[5–100] per visit][**(Unlimited benefit)**][**(limited to $**[100–20,000] **per Benefit Period)**]	[10–50]%][Not Covered][**(limited to $**[100–20,000] **per Benefit Period)**]
Surgery, Inpatient or Outpatient (For Transplants, see "Transplant Services," below)	[10–50]%][$[5–100] per visit][No Copayment]	[10–50]%][Not Covered]
Surgery, Outpatient Facility (including surgical procedures related to pregnancy and family planning)	[10–50]%][$[5–1,000]per visit]	[10–50]%][Not Covered]
Surgery, Outpatient Physician/Surgeon (including surgical procedures related to pregnancy and family planning)	[10–50]%][$[5–1,000] per visit]	[10–50]%][Not Covered]
Therapy: Chemotherapy, Dialysis and Radiation	[10–50]%][$[5–1,000] per visit][No Copayment]	[10–50]%][Not Covered]
Transplant Services (Must be received at a Facility that contracts with BCBSNM or with our national Transplant network.)		
Cornea, Kidney and Bone Marrow	10–50]%	[10–50]%][Not Covered]

[Name of Plan] benefit program benefits[: This benefit program does **not** cover services received from Nonpreferred Providers, except in an Emergency.]	**Member's Share of Covered Charges**	
	Preferred Provider	**Nonpreferred Provider**
Heart, Heart-Lung, Liver and Pancreas-Kidney [(Subject to a separate $[100–20,000] Out-of-Pocket Limit per Transplant type. Additional benefit maximums also apply. Benefit Period Deductible does not apply.)][**; combined max. of **$[100–5,000] per day for lodging and meals][; **$**[100–5,000] per Transplant for travel, meals and lodging][; lifetime max. of **$**[1,000–30,000] for travel, meals and lodging]	[10–50]%	[10–50]%][Not Covered]
Cornea, Kidney and Bone Marrow		
Office Visit Copayment	$[5–1,000] per visit	Not Covered
Inpatient Hospital/Facility Copayment	[10–50]%][$[100–5,000] per admission]	Not Covered
Emergency Room/Outpatient Facility Copayment	$[5–1,000] per visit	Not Covered
Heart, Heart-Lung, Liver and Pancreas-Kidney[(Subject to a separate $[100–20,000] Out-of-Pocket Limit per Transplant type. Additional benefit maximums also apply. Benefit Period Deductible does not apply.)][**; combined max. of **$[100–5,000] per day for lodging and meals][; **$**[100–5,000] per Transplant for travel, meals and lodging][; lifetime max. of **$**[1,000–30,000] for travel, meals and lodging]		
Office Visit Copayment	$[5–100] per visit	Not Covered
Inpatient Hospital/Facility Copayment	[10–50]%][$[100–5,000] per admission]	Not Covered
Emergency Room/Outpatient Facility Copayment	$[5–1,000] per visit	Not Covered
Urgent Care Facility	[10–50]%][$[5–1,000] per visit][No Copayment]	[10–50]%][Not Covered]

RETAIL PHARMACY[/SPECIALTY PHARMACY] DRUG PROGRAM

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods				
All covered drugs and other items are subject to the Deductible and Out-of-Pocket limit provisions. Certain drugs, special medical foods and enteral nutritional products require Prior Approval or benefits will be denied.	**Type of Prescription**	**Percentage of Covered Charge you pay (Coinsurance), if the percentage is between the minimum and maximum percentage amounts**	**Minimum Percentage Amount**	**Maximum Percentage Amount**
Retail Pharmacy Program (up to a **30-day supply** or **180 unit**, whichever is less.)	**Generic Drug**	[10–50]**%**	**$**[5–150]	**$**[10–500]
	Brand-Name Drug	[10–50]**%**	**$**[5–150]	**$**[10–500]

Mail-Order Program (up to a **90-day supply** or **540 units**, whichever is less.)	**Generic Drug**	[10–50]**%**	**$**[5–150]	**$**[10–500]
	Brand-Name Drug	[10–50]**%**	**$**[5–150]	**$**[10–500]
Non-Prescription Enteral Nutritional Products and Special Medical Foods (up to a **30-day supply**/30-day period, needs Prior Approval.)		[10–50]**%** of Covered Charges with no minimum or maximum amount; both Brand-name and Generic Drugs require Prior Approval		

Type of Prescription	Copayment/Coinsurance Amount
Generic Drug* or **Brand-Name Drug with generic Equivalent**	**$**[5–150] per prescription
Brand-Name Drug on Drug List (no generic equivalent)*	**$**[5–150] per prescription
Brand-Name Drug Not on Drug List (no generic equivalent)*	**$**[5–150] per prescription
Nonprescription Enteral Nutritional Products and **Special Medical Foods** (Brand-Name or generic; requires Prior Approval)	[10–50]**%** of Covered Charges per prescription
* For all Brand-Name Drugs with a generic equivalent, if you or your Provider order the Brand-Name Drug, you will pay the **Tier 1 Copayment** PLUS the **difference in cost** between the Brand-Name Drug and its generic equivalent.	

Type of Prescription	Copayment/Coinsurance Amount
Generic Drug*	**Tier 1: $**[5–150] per prescription
Brand-Name Drug on Drug List (no generic equivalent)*	**Tier 2: $**[5–150] per prescription
Brand-Name Drug Not on Drug List (no generic equivalent)	**Tier 3: $**[5–150] per prescription
Specialty Pharmacy Drug	**Tier 4:** [10–50]**%** of Covered Charges up to a maximum amount of **$** per prescription
Nonprescription Enteral Nutritional Products and **Special Medical Foods** (Brand-Name or generic; requires Prior Approval)	[10–50]**%** of Covered Charges per prescription
* For all Brand-Name Drugs with a generic equivalent, if you or your Provider order the Brand-Name Drug, you will pay the **Tier 1 Copayment** PLUS the **difference in cost** between the Brand-Name Drug and its generic equivalent.	

[MAIL ORDER SERVICE

Type of Prescription	Copayment/Coinsurance Amount
Generic Drug*	**Tier 1: $**[5–150] per prescription
Brand-Name Drug on Drug List (no generic equivalent)*	**Tier 2: $**[5–150] per prescription
Brand-Name Drug Not on Drug List (no generic equivalent)*	**Tier 3: $**[5–150] per prescription

Specialty Pharmacy Drug	Specialty Pharmacy Drugs are **not** covered through the Mail Order Service
Nonprescription Enteral Nutritional Products and **Special Medical Foods** (Brand-Name or generic; requires Prior Approval)	[10–50]**%** of Covered Charges per prescription
***** For all Brand-Name Drugs with a generic equivalent, if you or your Provider order the Brand-Name Drug, you will pay the **Tier 1 Copayment** PLUS the **difference in cost** between the Brand-Name Drug and its generic equivalent.	

ENROLLMENT AND TERMINATION INFORMATION

Unless otherwise specified in the Group Master Contract, all active employees who have completed the Employee Probationary Period and are regularly working the minimum number of hours specified in the Group Master Contract and their eligible Dependents are eligible for coverage. To find out the number of hours you must work per week and to learn of any other eligibility criteria specified by your Group, contact your Group Administrator.

Employers may request coverage for regular part-time employees expected to work an average of at least 20 hours per week over a 6-month period. Each employer may choose whether or not to offer health insurance to these part-time employees. Please contact your employer to find out if this optional coverage may affect you. (This optional coverage for part-time employees is not available to temporary or seasonal workers.)

BCBSNM may request proof that a valid employer-employee relationship exists, if applicable, and/or that the applicant meets the eligibility requirements stated in the Group Master Contract and the Member's application. The Group also agrees to permit BCBSNM to perform payroll audits.

See "Re-Enrollment" for important information if you or a Dependent were previously enrolled in a benefit program administered by BCBSNM.

MEDICARE-ELIGIBLE MEMBERS

Working employees and their spouses age 65 and over may be entitled to the same benefits as those employees under age 65.

Shortly before you turn age 65 or qualify for Medicare benefits for other reasons, you are responsible for contacting the local Social Security office to establish Medicare eligibility. You should then contact your Group Administrator to discuss coverage options.

If Medicare is Secondary — If an employee qualifies under the provisions of federal law for the working-aged (TEFRA), then the working employee age 65 or over and/or his/her spouse age 65 or over may continue this benefit program. In such cases, these benefit program benefits are primary over Medicare benefits. There are also other instances in which you may retain regular Group coverage when entitled to Medicare. Refer to a Medicare Handbook or contact the Social Security Administration for more information and eligibility guidelines that apply to you.

In any case, if you are a Medicare beneficiary and you *select* Medicare as your primary coverage, this benefit program is **not** available to you and your Group may not offer you any other employer-sponsored benefit program.

If Medicare is Primary — If federal law does not require that this Group coverage be primary over Medicare and your Group offers coverage that is secondary to Medicare, Members age 65 and older must change to the Group plan coverage that is secondary to Medicare. If offered through your Group, this coverage is available through BCBSNM. If you do not have both Parts A and B of Medicare or if you are under age 65, you must retain regular plan coverage until you obtain both Parts A and B of Medicare or until the beginning of the month in which you reach age 65. If your Group does not offer coverage secondary to Medicare, see "How to Continue Coverage" later in this section, for more continued coverage options.

Members of any age with both Parts A and B of Medicare may also choose to apply for an individual Medicare Supplemental Policy, which may require a health statement and/or a preexisting conditions waiting period. (The options available to individuals under age 65 and eligible for Medicare may differ from those available to individuals age 65 and older.)

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The Subscriber must notify BCBSNM **within 31 days** following any changes that may affect his/her or a Dependent's eligibility, including a change to a covered family member's name or address, by indicating such changes on an enrollment/change form and submitting it to BCBSNM. You can obtain this form at the BCBSNM Web site at [**www.bcbsnm.com**], from the Group Administrator or by calling the BCBSNM Customer Service department. (Members covered under federal continuation must submit enrollment/change forms directly to the COBRA Administrator.)

APPLYING FOR COVERAGE

An eligible person can apply for coverage, including for his/her eligible Dependents, by submitting an enrollment/change form to BCBSNM **within 31 days** after becoming eligible according to the terms of the Group Master Contract. **Note:** BCBSNM cannot use genetic information or require genetic testing in order to determine if a condition is preexisting or to limit or deny coverage.

BCBSNM will determine your Effective Date of Coverage according to the provisions of the Group Master Contract.

This benefit program does not cover any service received before your Effective Date of Coverage (which, for eligible Dependents, may be later than the Subscriber's effective date). Also, if your prior coverage has an extension of benefits provision, this benefit program will not cover those charges incurred after your effective date that are covered under the prior plan.

ADDING DEPENDENTS

A Subscriber may apply for coverage of a newly acquired Dependent (such as a new spouse or a newborn child). **Within 31 days** of acquiring the new Dependent or before adding a new spouse to coverage, the Subscriber must:

- request that the Group notify BCBSNM of the change,
- complete and submit all necessary enrollment/change forms and legal documentation of proof of dependency and
- pay any additional premium or other employee contribution for coverage, which may mean changing from [Individual to Two-Person, Employee/Children or Family coverage.][Individual to Family Coverage.]

[Unless listed as an exception under "Preexisting Conditions Limitation," each Dependent added to coverage is subject to the Preexisting Conditions limitation.]

Adding a New Spouse

If a Subscriber adds coverage for a new spouse **within 31 days** of marriage, the effective date of the spouse's coverage will be the first of the month following the date of marriage. If the Subscriber does not submit a completed and signed enrollment/change form to his/her Group Administrator or to BCBSNM (or to the COBRA Administrator), along with necessary documentation and, if required, change from [Individual to Two-Person or Family coverage] [Individual to Family coverage] **within 31 days** of marriage, the spouse may not be added to coverage except as a Late Applicant (or as specified under "Special Enrollment").

Adding a Dependent Child

If you do not submit an application for a newly acquired Dependent child or add additional coverage, if required, within the time frames below, the child will be considered a Late Applicant, except as specified under "Special Enrollment."

Adding Newborn Children

[If Family or Employee/Children][If Family] coverage is in effect, a newborn, natural child is covered from birth. (You should, however, submit an application to add the newborn as a Dependent as soon as possible after birth.) [If Family or Employee/Children][If Family] coverage is not in effect, you must change to [Family or Employee/Child(ren)][Family] coverage **within 31 days** of the birth in order for newborn care to be covered. If the application is not received **within 31 days** and additional premium or other employee contributions for coverage, if any, are not paid, the newborn is considered a Late Applicant. [**Remember:** The Preexisting Conditions limitation will apply to a Late Applicant newborn unless the child was previously enrolled in a Group Health Care Plan or other Creditable Coverage **within 31 days** of his/her birth and has had prior Creditable Coverage since that date with no significant lapse (i.e., 63 or more days).]

Note: If the parent of the newborn is a Dependent child of the Subscriber (i.e., the newborn is the Subscriber's grandchild), benefits are not available for the newborn.

Adding Adopted Children

A child under age 18 placed in the Subscriber's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage can be made as late as **31 days** following legal adoption without being considered late. (Although a child over the age of 18 is not eligible for adoption, an adopted child is covered as any other child, subject to the same Dependent age limitations and restrictions.) [**Note:** The Preexisting Conditions limitation will apply to a Late Applicant unless the child was previously enrolled in a Group Health Care Plan or other Creditable Coverage **within 31 days** of his/her adoption or placement for adoption and has had prior Creditable Coverage since that date with no significant lapse (i.e., 63 or more days).]

Legal Guardianship

Application for coverage must be made for a child for whom the Subscriber or the Subscriber's spouse becomes the legal guardian **within 31 days** of the court or administrative order granting guardianship.

Court Ordered Dependent Coverage

When an employee or employer is required by a court or administrative order to provide coverage for a Dependent child, the Dependent may be enrolled in the Subscriber's [Family or Employee/Children][Family] coverage and will **not** be considered a Late Applicant. (If the Subscriber has [Individual or Two-Person][Individual]coverage, he/she may be required to pay additional premium in order for the Dependent to be added.) If not specified in the court or administrative order, the Dependent's Effective Date of Coverage will be the date the order has been filed as public record with the State or the effective date of [Family or Employee/Child(ren)][Family] coverage, whichever is later. BCBSNM must receive a copy of the court or administrative order.

SPECIAL ENROLLMENT

There are two instances ("qualifying events") in which an eligible person can obtain a "special enrollment" right and enroll in this benefit program **more than 31 days** after becoming eligible without being considered a Late Applicant under the "Preexisting Conditions Limitation." You have a limited amount of time during which you may request a special enrollment. If you do not request special enrollment within the time frames described below, you will be considered a Late Applicant.

If a Member is granted a special enrollment due to Involuntary Loss of Coverage or due to marriage, coverage will begin no later than the first day of the month after BCBSNM received the request for special enrollment (for a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption).

Note: There are no special enrollments for persons applying for any extension of benefits, continuation or conversion coverage offered under this benefit program. You must enroll in these coverages timely.

Applying for Special Enrollment

Application for special enrollment must be made **within 31 days** of losing other coverage or experiencing a change in family status in order to qualify you and/or your Dependent(s) for a special enrollment right (switch enrollment may be available to Members who are offered more than one benefit program option). Please contact your Group Administrator for details about special enrollment privileges that apply to you and your eligible family members.

Waiver of Coverage

If you or an otherwise eligible member (or members) of your family decline to enroll in this benefit program when initially eligible to do so, you (the employee) must sign a waiver of coverage for yourself and/or the affected Dependent(s) and submit it to your employer. **It is very important that you indicate the reason for declining coverage.** If the eligible person(s) declined coverage due to having other health care coverage and later involuntarily loses the other coverage, you and your eligible Dependent(s) may be eligible to enroll in your employer's group plan as "special enrollees." Waivers of coverage must be submitted to your employer **within 31 days** of becoming eligible for coverage under your employer's health care benefit program. (If the person declining coverage later requests a special enrollment, but no such written statement was provided, or if the reason for declining coverage was not due to having other coverage, he/she will be ineligible for special enrollment. If enrolled, the person will be considered a Late Applicant.)

Coverage Effective Date

If a Member is granted a special enrollment due to Involuntary Loss of Coverage or due to marriage, coverage will begin no later than the first day of the month after BCBSNM (or the employer) received the request for special enrollment. For a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption.

Qualifying Events

The two instances of special enrollment are:

Loss of Prior Coverage

An eligible employee (and/or his/her Dependent) who declined coverage when initially eligible because of having other comprehensive medical coverage and who later *involuntarily* loses the other coverage or who reaches a lifetime maximum under the prior plan, may apply for coverage for himself/herself and eligible Dependents. If application is made **within 31 days** of losing the other coverage or **within 31 days** of receiving the first denial notice informing the applicant that he/she had reached a lifetime limit, the applicant(s) will **not** be considered a Late Applicant. If application is **not** made **within 31 days**, the employee and his/her Dependents will be considered Late Applicants.

BCBSNM reserves the right to verify the applicant's eligibility for coverage by requesting proof of loss of coverage or proof of the date of the event. A person declining coverage due to having other health care coverage must provide a written statement indicating his/her reason(s) for doing so. (If the person later requests a special enrollment, but no such written statement was provided, he/she will be considered a Late Applicant.)

Change in Family Status

An employee who declined coverage when initially eligible but who later acquires a new eligible Dependent may apply for coverage. The application for the employee and his/her Dependents will **not** be considered late if submitted **within 31 days** of the day the employee acquired the new Dependent.

[PREEXISTING CONDITIONS LIMITATION

Timely Applicants and Special Enrollees

No benefits are available for any Preexisting Conditions for [3–6] **months** after the Member's Initial Enrollment Eligibility Date.

Late Applicants

For a Late Applicant, no benefits are available for any Preexisting Conditions for [6–18] **months** after his/her Effective Date of Coverage.

Exceptions — The following Members are **not** subject to this Preexisting Conditions limitation:

- newborn child (when [Family or Employee/Children][Family] coverage is in effect on the date of birth)
- newborn child added to coverage **within 31 days** of birth (when [Family or Employee/Children][Family] coverage is not in effect on the date of birth)
- adopted child under age 18 (or child under age 18 placed in the Subscriber's home for the purpose of adoption) and added to coverage **prior to** or **within 31 days** of adoption
- a newborn or adopted child who was enrolled in any Group Health Care Plan or other Creditable Coverage **within 31 days** of birth or adoption and who has not experienced any significant lapse of coverage (i.e., 63 or more days) prior to enrolling in this benefit program

Reduction in Waiting Period

The Preexisting Conditions Waiting Period will be reduced for any Member who had comprehensive medical/surgical coverage that was either still in effect or was terminated **within 63 days** of his/her Initial Enrollment Eligibility Date under this benefit program. The Waiting Period will be reduced by at least the length of time he/she was continuously covered under the prior plan(s).

You can add up any Creditable Coverage you had prior to enrollment in this benefit program, but if you went for **63 days or more** without any Creditable Coverage (excluding any excepted time periods outlined below), the coverage you had before the break will not be counted. Proof of such prior Creditable Coverage (e.g., Certificate of Creditable Coverage) is required before credit will be given.

What is Not Considered a Break in Coverage

For purposes of determining any significant break in coverage (i.e., 63 or more days), lapses in coverage due to any of the following situations will not be considered as part of a break:

- a Waiting Period imposed by a Group Health Care Plan before it allowed you to become eligible for enrollment
- the amount of time between the date you submitted a substantially complete application for individual plan coverage and either the date the coverage began (if you were accepted), the date on which the application was denied or on the date upon which the offer of coverage lapsed (if you were not accepted)
- the period of time between loss of coverage and COBRA election for certain workers whose employment was adversely affected by international trade and who were entitled to a second COBRA election period as a result

For any employee who lost coverage due to military service (and his/her eligible Dependents), was re-employed under the provisions of the USERRA of 1994 and applied for reinstatement of coverage according to the timeliness limitations of the USERRA of 1994, the Preexisting Conditions Waiting Period will continue to be credited during the time the employee is in military service.]

RE-ENROLLMENT

[If a previously covered employee and/or Dependent is re-enrolled in this benefit program, he/she will usually be considered a Late Applicant. See "Preexisting Conditions Limitation" and "Special Enrollment" for exceptions and details.]

Any individual whose previous BCBSNM contract was terminated for Good Cause is not eligible to re-enroll in this benefit program, unless approved in writing by BCBSNM (Members currently enrolled in continuation coverage may not re-enroll once coverage is terminated, unless eligibility under this benefit program is re-established.)

COVERAGE TERMINATION

Unless stated otherwise, if you do not elect or do not qualify for continuation coverage (see "How to Continue Coverage"), coverage ends at the end of the month following the earliest of the date:

- The employee **terminates employment** or **otherwise loses eligibility** according to the terms of the Group Master Contract. If the Group or Subscriber fails to notify BCBSNM **within 30 days** to remove an ineligible person from coverage, BCBSNM may recover any payment made on the ineligible person's behalf.
- When the **premium payment** or other employee contribution for coverage is not received on time. (Coverage will be suspended if premium is not paid when it is due. If premium is not received **within 30 days** after its due date, the Group or affected Member(s) will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 30-day grace period will be billed both to the Subscriber and to the Group or, in the case of continuation coverage, to the Subscriber.)
- When the Member begins a **leave of absence** or enters the **armed forces** for **more than 30 days** or as provided by law. (See "Leave of Absence or Military Services.")
- When the **Member materially fails to abide by the rules,** policies or procedures of this benefit program or fraudulently provides or materially misrepresents information affecting coverage. If a Member knowingly gave false material information in connection with the eligibility or enrollment of the Subscriber or any of his/her Dependents, BCBSNM may terminate the coverage of the Subscriber and his/her Dependents retroactively to the date of initial enrollment. The Subscriber is liable for any benefit payments made as a result of such improper actions.
- When the Subscriber **dies**. (Surviving eligible Dependents remain covered through the last-paid billing period.)
- If this benefit program is primary over **Medicare** due to federal laws and regulations, when the Medicare-eligible Member *chooses* Medicare as his/her primary coverage. (See "Medicare-Eligible Members" for information on coverage options for Members who are entitled to Medicare.)
- At the *beginning* of the month when the Member becomes **age 65** (excepting any laws to the contrary that apply to certain large group employer health plans). See "How to Continue Coverage" for more information regarding continued coverage options in these cases.
- When the Member acts in a **disruptive** manner that prevents the orderly business operation of any network Provider or dishonestly attempts to gain a financial or material advantage.

- When **Group coverage is discontinued** for the entire Group or for the employee's enrollment classification.
- When the Group gives BCBSNM or BCBSNM gives the Group a minimum **30 days' advance written notice**.

If BCBSNM ceases operations, BCBSNM will be obligated for services for the rest of the period for which premiums were already paid.

Additional Dependent Termination Reasons

In addition, coverage will end for any Dependent on the earliest of the above dates or the earliest of the following dates:

- At the end of the **last-paid billing period** for Dependent coverage.
- At the end of the month when a child **no longer qualifies as a Dependent** under the benefit program (e.g., a child is removed from placement in the home, marries or reaches the Dependent age limit, unless the child is medically certified as handicapped).
- At the end of the month following the date of a final **divorce** decree or **legal separation** for a spouse.
- At the end of the month when the Subscriber gives a minimum **30 days' advance notice** in writing to end coverage for a Dependent(s), according to the rules of your plan as established by your Group.

If a Dependent is being removed from coverage because of losing his/her eligibility under the benefit program (for reasons other than reaching the Dependent child age limit), the enrollment/change form must be received by BCBSNM **within 31 days** following the effective date of the change. In these cases, the Member will be removed from coverage as of the end of the month following the change in his/her eligibility status. BCBSNM and the Providers of care may recover benefits erroneously paid on behalf of the removed Member.

Note: If enrolled under federal continuation, send enrollment/change forms to the COBRA Administrator.

Voluntary Termination of Coverage

To remove a Dependent from coverage before loss of eligibility or to voluntarily terminate his/her own coverage, the Subscriber must submit a completed enrollment/change form to his/her Group Administrator. If voluntary termination is allowed under your plan outside the annual renewal period, coverage will end the first of the month following receipt of the enrollment/change form. Voluntarily terminated Members may re-enroll under the benefit program only as Late Applicants (except as provided under "Special Enrollment"). Also, these Members are **not** eligible for any extension of benefits or federal[or state] continuation or conversion coverage.

Note: If enrolled under federal continuation, send enrollment/change forms to the COBRA Administrator.

Termination of Continuation Coverage or Extension of Benefits

See "How to Continue Coverage" for more information.

Leave of Absence or Military Service

Coverage will end for a Subscriber and his/her eligible Dependents at the end of the month during which the leave began. During a leave of absence covered by the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage will continue as provided by law. Contact your Group Administrator for information.

NOTIFICATION

If the Group Master Contract is terminated or premiums are not submitted, coverage will terminate for all affected Members as of the end of the last-paid billing period. The affected Members and the Group will **not** be notified of such terminations. (If your Group fails to submit premium payments to BCBSNM, it is your Group's responsibility to advise Members of BCBSNM benefit program termination.)

The required premiums are determined and established by BCBSNM. The percentage of the total premium that you pay is established by your Group. BCBSNM may change premium amounts according to any of the following:

- changes in federal and state law; or

- changes to coverage classifications (for example, to a new age category or geographic location or from an individual coverage to family coverage type); or
- after giving the Group and/or Subscriber **60 days'** written notice.

PREMIUM REFUNDS

BCBSNM may not refund membership premiums paid in advance on behalf of a terminated Member if:

- the enrollment/change form is not received **within 31 days** of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the terminated Member during the period for which premiums have been paid.

HOW TO CONTINUE COVERAGE

If you lose coverage under this benefit program, you may be able to continue coverage for a limited period of time. **Note:** There is no special enrollment under these provisions. You must enroll timely to qualify for continued coverage.

Extension of Benefits

If you are Totally Disabled on the date your Group's BCBSNM Group coverage terminates, your health care coverage may be continued (for only the disabling condition) for **up to 12 consecutive months** after the Group terminates coverage with BCBSNM.

An extension of benefits is available if you:

- were Totally Disabled on the date of the Group's termination; and
- incur an expense directly resulting from that particular disability that would have been a Covered Service before termination.

If coverage is continued under this provision, benefits for the disabling condition are paid subject to all applicable limitations, exclusions and maximums that applied at the time the Group's coverage terminated. To claim an extension of benefits, you must notify BCBSNM **within 31 days** of the Group's coverage termination date and provide evidence of your Total Disability.

Continuation Coverage

Your Group may be subject to the provisions for continuation of plan coverage under federal law (COBRA or USERRA)[or state law (six-month continuation)]. If so, employees and their covered Dependents who lose eligibility under this benefit program may be able to continue as Members, without a health statement, for a limited period of time by purchasing the continuation coverage described below. You must pay premiums from the date of loss of Group coverage.

You are not eligible to enroll for continuation coverage if:

- the Group stops offering this coverage to its employees or
- you do not elect continuation coverage in a timely fashion.

In addition, if you elect state continuation coverage, you may not later enroll in federal continuation coverage. Contact your Group Administrator for details about enrolling in continuation coverage.

Continuation coverage is identical to the coverage a similarly situated regular Member has. However, if the coverage for regular Members changes, your continuation coverage will reflect the same change. For example, if the benefit program's Deductible or other cost-sharing amounts change for regular Members, yours will change by the same amount.

Federal Continuation (COBRA)

Unless approved in writing by BCBSNM, the following persons may **not** enroll in this continued coverage option:

- one who **voluntarily** terminated coverage while still eligible
- a Dependent who was removed from coverage by the Subscriber while the Dependent was still eligible

- any Member whose BCBSNM health care coverage was terminated for Good Cause

Continuation coverage under federal law ends on the **earliest** of the following dates or any of the applicable dates listed under "Coverage Termination" earlier in this section:

- the first of the month when you become entitled to Medicare
- when the Group discontinues offering this benefit program to employees (If this benefit program is replaced by another health care plan, continuation coverage will also be replaced by the new plan.) **Exception:** If your Group declares bankruptcy and you are covered under this benefit program as a retiree, you and your Dependents may be eligible for continued coverage.
- when you become covered under another Group Health Care Plan (However, if that health plan includes a preexisting conditions limitation, continuation coverage will not end until that limitation has been satisfied or until another event occurs which would make you ineligible for continued coverage.)
- when the continuation period expires (If this Group's benefit program is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under "Conversion to Individual Coverage.")

[State Continuation Coverage

A Subscriber and his/her covered Dependents may continue plan coverage for **6 months** after losing coverage for any reason other than nonpayment of premium or termination of the entire Group. BCBSNM must receive the application for state continuation coverage **within 31 days** after Group coverage is lost. (A health statement is not required.)

State continuation coverage ends on the **earliest** of the following dates or of the applicable dates listed under "Coverage Termination" earlier in this section:

- when the Group discontinues offering this benefit program to employees (If this benefit program is replaced by another health care plan, continuation coverage will also be replaced by the new plan.)
- when the continuation period expires (If this Group's benefit program is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under "Conversion to Individual Coverage.")

If you are entitled to both Parts A and B of Medicare, your state continuation coverage option is limited to a Medicare Supplemental Plan administered by BCBSNM. Depending upon your age and the plan you select, a health statement may be required and a preexisting conditions limitation may apply. (The options for Members under age 65 are limited.) Call a Customer Service representative for more information.]

USERRA Continuation Coverage

Employees and their covered Dependents who lose Group coverage because the employee is absent from work due to military service may be able to continue coverage for **up to 24 months** after the absence begins. Contact your Group Administrator for details about the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Direct-Pay Premium Payments

Subscribers under federal COBRA continuation coverage must pay premiums to the COBRA Administrator. Subscribers under state continuation coverage pay premiums to BCBSNM. Contact your Group Administrator for an application for coverage and details.

Premiums for coverage may change on your Group's renewal date or on any date that the plan is amended. Written notice of any such change will be given to the Group or Subscriber **at least 60 days** before the effective date of the premium change.

CONVERSION TO INDIVIDUAL COVERAGE

Involuntarily terminating Members may change to individual (direct-pay) conversion coverage if this benefit program is still in effect and coverage is lost due to one of the following circumstances:

- termination of employment
- a Member no longer meets the eligibility requirements of the Group Master Contract
- the period of continuation coverage expires
- a Dependent loses coverage for one of the following reasons:
    - — divorce or legal separation from the Subscriber
    - — disqualification of the Member under the definition of a Dependent
    - — death of the Subscriber
    - — an employee becomes primary under Medicare — leaving Dependents without coverage

The Subscriber and any eligible Dependents *who were covered* at the time that Group coverage was lost are eligible to apply for conversion coverage without a health statement.

BCBSNM must receive your application for conversion coverage **within 31 days** after you lose eligibility under the Group/continuation plan. **You must pay conversion coverage premiums from the date of such termination.**

Conversion coverage is **not** available in the following situations:

- when Group coverage under this benefit program was discontinued for the entire Group or the employee's enrollment classification
- when you reside outside of or move out of New Mexico (Call BCBSNM for details on transferring coverage to the Blue Cross Blue Shield Plan in the state where you are living.)

If you are entitled to Medicare, your conversion coverage option is limited to a Medicare Supplemental Plan administered by BCBSNM. Depending upon your age and the plan you select, a health statement may be required and a preexisting conditions limitation may apply. (The options for Members under age 65 are limited.) Call a Customer Service representative for the enrollment options available to you.

The benefits and premiums for conversion coverage will be those available to terminated health care plan Members on your coverage termination date. You will receive a new Benefit Booklet if you change to conversion coverage. (Some benefits of this benefit program are not available under conversion coverage.) Contact a Customer Service representative for details.

THINGS YOU SHOULD KNOW

This section of the Benefit Booklet describes some important features you should know about your coverage.

DEFINITIONS

Throughout this Benefit Booklet, many words are used that have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Benefit Booklet, please refer to *Definitions* because they will help you understand some of the limitations or special conditions that may apply to your benefits.

[BENEFIT HIGHLIGHTS

Throughout this Benefit Booklet, you are asked to refer to a separately issued *Benefit Highlights* insert that shows specific Member cost-sharing amounts and coverage limitations of your benefit program. If you do not have a *Benefit Highlights* insert, please contact a BCBSNM Customer Service representative (the phone number is at the bottom of each page of this Benefit Booklet). You will receive a new *Benefit Highlights* insert if changes are made to your benefit program.]

IDENTIFICATION (ID) CARD

You will receive a BCBSNM Identification (ID) Card. The ID Card contains your Group number and your identification number (including an alpha prefix) and tells Providers that you are entitled to benefits under this benefit program with BCBSNM.

This card is part of your coverage. Always carry it with you. Do not let anyone who is not named in your coverage use your card to receive benefits. If you need an additional card or to replace a lost card, contact a Customer Service representative.

PROVIDER NETWORK DIRECTORY

The Provider network directory is available through the BCBSNM Web site at [**www.bcbsnm.com**]. It lists all Providers in the BCBSNM Preferred Provider network, including Mental Health/Chemical Dependency Providers[and Participating Pharmacies]. It also provides links to the listings of Preferred Providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service. It will be mailed to you free of charge.) **Note:** Although Provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a Provider's status or if you have any questions about the directory, contact a Customer Service representative or visit the BCBSNM Web site at [**www.bcbsnm.com**].

[DRUG PLAN BENEFITS

BCBSNM has contracted with a separate pharmacy benefit manager to administer your outpatient drug plan benefits. In addition to your Benefit Booklet, you will be sent important information about your drug plan benefits.[See your separately issued *Drug Plan Rider* for more information about the drug plan Copayments and/or Coinsurance amounts.][[See *Prescription Drugs and Other Items* for more information about the drug plan Coinsurance amounts.]]

BLUECARD BROCHURE

As a member of a PPO health plan administered by BCBSNM, you take your health plan benefits with you – across the country and around the world. The BlueCard Program gives you access to Preferred Providers almost everywhere you travel or live. Almost 80 percent of Physicians in the United States contract with Blue Cross Blue Shield Plans, so you and your Dependents can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care Providers that contract as Preferred Providers with their local BCBS Plan. You should receive a brochure describing this program in more detail. It's a valuable addition to your health care plan coverage. Instructions for locating a Preferred Provider outside New Mexico are in the brochure or can be found on the BCBSNM Web site at [**www.bcbsnm.com**].

[BLUEEDGE HCA BROCHURE

As a participant in the Health Care Account (HCA) program, you will receive additional materials describing how the special employer-funded "Health Care Account" (HCA) reimbursement program works with this BlueEdge Preferred

Provider coverage. Your Identification Card will indicate which BlueEdge HCA program under which you are enrolled.]

[BLUEEDGE HSA BROCHURE

As a participant in the Health Savings Account (HSA) program, you will receive additional materials describing how the "Health Savings Account" (HSA) works with this BlueEdge Preferred Provider coverage. Your Identification Card will indicate the BlueEdge HSA program under which you are enrolled.]

LIMITATIONS AND EXCLUSIONS

Each provision in *Covered Services* not only describes what is covered, but may list some limitations and exclusions that specifically relate to a particular type of service. The *General Limitations and Exclusions* section lists limitations and exclusions that apply to *all* services.

[PREFERRED PROVIDER BENEFIT ONLY

The services listed below are eligible for benefits **only** when received from Preferred Providers:

- [Transplant and Transplant-Related Services (Services must be received at a Facility that contracts with BCBSNM, the local BCBS Plan or the national BCBS Transplant network, for the Transplant being provided.)]
- [psychotherapy for Chemical Dependency (Alcoholism or Drug Abuse) and Mental Health Disorders]
- [Outpatient Cardiac and Pulmonary Rehabilitation]
- [Physical, Occupational and Speech Therapy[, including physical rehabilitation Admissions]
- [spinal manipulation]
- [Acupuncture]
- [Skilled Nursing Facility services]
- [smoking/tobacco use Cessation Counseling]
- [adult Preventive Care Services]
- [Preventive Care Services]
- [adult Preventive Care Services and/or routine child care]
- [allergy care]
- [prosthetics, orthotics, Durable Medical Equipment and Medical Supplies]]

ADMISSION REVIEW OR OTHER PRIOR APPROVAL REQUIRED

To receive full benefits for some[nonemergency][medical/Surgical] services, you or your Provider must call the BCBSNM Health Services department **before** you receive treatment. Call Monday through Friday, [8 a.m. to 5 p.m.,] Mountain Time. See *Admission Review and Other Prior Approvals* for details. **Note:** Call Customer Service if you need Prior Approval assistance after [5 p.m.]

[Emergency/Maternity Admission Notification

To receive full benefits for Emergency Hospital Admissions, you (or your Provider) must notify BCBSNM **within 48 hours** of Admission or as soon as reasonably possible following Admission. Call BCBSNM's Health Services department, Monday through Friday, [8 a.m. to 5 p.m.,] Mountain Time. Also, if you have a routine delivery and stay in the Hospital **more than 48 hours**, or if you have a C-section delivery and stay in the Hospital **more than 96 hours**, you must call BCBSNM for Admission approval before you are discharged.]

[Emergency Admission Notification

To ensure that benefits are correctly paid and that an Admission you believe is Emergency-related will be covered, you, your physician or Hospital should notify BCBSNM **within 48 hours** or as soon as reasonably possible following Admission. Call BCBSNM's Health Services department, Monday through Friday, [8 a.m. to 5 p.m.], Mountain Time.]

Written Request Required

If a **written request** for Prior Approval is required in order for a service to be covered, the Provider should send the request, along with appropriate documentation, to:

[**Blue Cross and Blue Shield of New Mexico**
Attn: Health Services Department
P.O. Box 27630
Albuquerque, NM 87125–7630]

Please ask your health care Provider to submit your request early enough to ensure that there is time to process the request before the date you are planning to receive services.

[CALL MESA MENTAL HEALTH FOR PRIOR APPROVAL

For all Inpatient and Outpatient Mental Health and Chemical Dependency services, you or your Physician must call the BCBSNM Behavioral Health Services Administrator, Mesa Mental Health, **before** you schedule treatment. Mesa Mental Health will coordinate Covered Services with a Preferred Provider near you. If you do not call before receiving nonemergency services, benefits for Covered Services may be reduced or denied. Call 7 days a week, 24 hours a day. See *Admission Review and Other Prior Approvals* for details.]

HEALTH CARE FRAUD INFORMATION

Health care and insurance fraud results in cost increases for health care plans. You can help; always:

- Be wary of offers to waive Copayments, Deductibles or Coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your Providers and the *Explanation of Benefits* (EOB) you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call a BCBSNM Customer Service representative.
- Be very cautious about giving information about your health care insurance over the phone.

If you suspect fraud, contact the BCBSNM Fraud Hotline at [1-888-841-7998].

CUSTOMER ASSISTANCE

Refer to *Customer Assistance* for important phone numbers, Web site and mailing address information.

ADMISSION REVIEW AND OTHER PRIOR APPROVALS

You or your Provider must obtain authorization from BCBSNM *before* you are admitted as an Inpatient (Admission review approval) or receive certain types of services (other Prior Approvals).

In order to receive benefits:

- services must be listed as covered and Medically Necessary;
- services must not be excluded; and
- the procedures described in this section must be followed regardless of where services are rendered or by whom.

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care. **Please note:**

Prior Approval determines only the Medical Necessity of a specific service and/or an Admission and an allowable length of stay. **Prior Approval does not guarantee your eligibility for coverage, that benefit payment will be made or that you will receive the highest level of benefits.** Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this benefit program and services that are not Medically Necessary will be **denied**.

Even when this benefit program is not your primary coverage, these approval procedures must be followed. **Failure to do so may result in a reduction or in a denial of benefits.**

Most Prior Approval requests will be evaluated and you and/or the Provider notified of BCBSNM's decision **within 15 days** of receiving the request (**within 72 hours** for Urgent Care requests). If requested services are not approved, the notice will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial[(see "If Your Prior Approval Request is Denied" later in this section)].

Retroactive approvals will not be given and you may be responsible for the charges if Prior Approval is not obtained **before** the service is received.

BCBSNM PREFERRED PROVIDERS

If the attending Physician is a Preferred Provider that contracts **directly** with BCBSNM, obtaining Prior Approval is not your responsibility — it is the Provider's.[PPO Primary Providers (PPPs) and other] Preferred Providers contracting with BCBSNM must obtain **Prior Approval** from BCBSNM [(or from Mesa Mental Health, when applicable)] in the following circumstances:

- when recommending any nonemergency Admission, readmission or transfer
- when a covered newborn stays in the Hospital longer than the mother
- before providing or recommending a service listed under "Other Prior Approvals," later in this section

Note: Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the Prior Approval requirements of BCBSNM. Unless a Provider contracts directly with BCBSNM as a Preferred Provider, the Provider is not responsible for being aware of this benefit program's Admission review and other Prior Approval requirements.

NONPREFERRED PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

If any Provider outside New Mexico (except for those contracting as Preferred Providers directly with BCBSNM) or any Nonpreferred Provider recommends an Admission or a service that requires Prior Approval, the Provider is **not** obligated to obtain the Prior Approval for you. In such cases, it is **your** responsibility to ensure that approval is obtained. [**Remember:** Nonpreferred Providers are covered only for Emergency Care and in those specific circumstances described under *How Your Plan Works.*]

If approval is not obtained **before** services are received, **you will incur a penalty for a covered Admission or, for some services, be entirely responsible for the charges.** The Provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM [(or Mesa Mental Health, when applicable)] is called.

ADMISSION REVIEW APPROVAL

Admission review is required for most admissions **before** you are admitted to:

- [the Hospital]
- [Skilled Nursing Facility]
- [physical Rehabilitation Facility]
- [other treatment Facility]

Benefits for covered Facility services will be **reduced** or **denied**, if you do not obtain Admission review approval as follows:

- **Nonemergency:** Before the patient is admitted.
- **Emergency, nonmaternity: Within 48 hours** of the Admission. If the patient's condition makes it impossible to call **within 48 hours**, call as soon as possible.
- **Maternity-related** (including eligible newborns when the mother will not be covered)**:** Before the mother's Maternity due date, soon after pregnancy is confirmed. However, you should always call **within 48 hours** of the Admission for routine deliveries (**96 hours** for C-sections). If the mother's condition makes it impossible to call **within 48 (or 96) hours**, call as soon as possible.
- **Extended Stay, Newborn** (when an eligible newborn stays in the Hospital longer than the mother)**:** Before the newborn's mother is discharged.

HOW THE APPROVAL PROCEDURE WORKS

When you or your Provider call, BCBSNM's Health Services representative will ask for information about your medical condition, the proposed treatment plan and the estimated length of stay. The Health Services representative will evaluate the information and notify the attending Physician and the Facility (usually at the time of the call) if benefits for the proposed hospitalization are approved. If the Admission is not approved, you may appeal the decision as explained later in this section.

Penalty for Not Obtaining Approval

If you or your Provider **do not call** or if you call and **do not receive approval** for Inpatient benefits, but you choose to be hospitalized anyway, **no** benefits may be paid or partial payment may be made, as indicated below if:

- **the Admission was not for a Covered Service,** benefits for the Facility and all related services will be **denied.***
- **the Admission was for an item listed under "Other Prior Approvals," (e.g., high-dose chemotherapy),** benefits for the Facility and all related services will be **denied.***
- **the Admission was for any other Covered Service but hospitalization was not Medically Necessary,** benefits will be **denied** for **room, board** and **other charges** that are not Medically Necessary.*
- **the Admission was for a Medically Necessary Covered Service (nonemergency),** benefits for the Facility's Covered Services will be reduced by **$**[$100–$1,000].

* The Admission review penalty of **$**[$100–$1,000] and charges for noncovered and denied services are **not applied** to any Deductible or Out-of-Pocket Limit.

Admission review requirements may affect the amounts that this benefit program pays for Inpatient Services, but they do not deny your right to be admitted to any Facility and to choose your services.

[OTHER PRIOR APPROVALS

In addition to Admission review for all Inpatient Services, Prior Approval is required for certain other services. Most Prior Approvals may be requested over the telephone. If a *written* request is needed and you call, a Health Services representative will give you instructions for filing a written request for Prior Approval.

If Prior Approval is not obtained, **benefits will be denied** for the following services and all related services:

- [**air Ambulance** services (unless during an Emergency)]
- [**Alcoholism** or **Drug Abuse** services][(Prior Approval is obtained from Mesa Mental Health.)]
- [**Cardiac** or **Pulmonary Rehabilitation**]
- [**Chemotherapy** (high-dose)]

- [**Dental-Related Services** in a Hospital or other Facility (the procedure may not be covered even if benefits for the hospitalization are approved as Medically Necessary; see *Covered Services)*; treatment of **Accidental Injuries to teeth** (except initial treatment); treatment of **orthognathism**]
- [**diabetes self-management** educational programs; **insulin pumps; diabetic supplies;** and **equipment** costing **$**[$100–$1,000] **or more**]
- [**Durable Medical Equipment,** Medical Supplies and Prosthetic devices costing **$**[$100–$1,000] **(or more)** or requiring **long-term rental; Orthopedic Appliances, Orthotics** and **surgically implanted Prosthetics,** regardless of total cost]
- [**Enteral Nutritional Products, Special Medical Foods** and **certain drugs** covered under [the *Drug Plan Rider*][*Prescription Drugs and Other Items*;] prescription **refills** before the supply should have been exhausted]
- [**health education** and **counseling** programs]
- [**home Dialysis**]
- [**Home Health Care** and **home I.V.** services]
- [**Hospice care**]
- [**infertility-related services** (Only limited services are covered.)]
- [certain **injections**]
- [**PET scans; cardiac CT scans; home sleep studies; genetic testing or counseling; infertility testing**]
- [**private room charges**]
- [**psychiatric intake evaluations** and **medication checks; electroshock therapy** and **narcosynthesis; psychological testing; psychotherapy** ([Outpatient Services require Prior Approval from Mesa Mental Health or benefits will be denied.]For Inpatient Services that are not related to Chemical Dependency, you must obtain Admission approval or benefits for Covered Services will be reduced by **$**[$100–$1,000].)]
- [**rehabilitative services** (Inpatient and Outpatient Physical, Occupational and Speech Therapy, including Skilled Nursing Facility services)]
- [**smoking/tobacco use cessation** drug therapy]
- [certain **Surgical Services,** including:
  - [**breast reduction**]
  - [**breast Surgery following a mastectomy** (**Note:** This is the only Cosmetic procedure covered under this benefit program.)]
  - [**cochlear implants**]
  - [**Dental-Related Services/oral Surgery** services in a Hospital or other Facility (the procedure may not be covered even if benefits for the hospitalization are approved as Medically Necessary); Surgical Services for **Accidental Injuries to teeth** (except initial treatment); and **orthognathic Surgery**]
  - [**orthotripsy**]
  - [**reconstructive Surgical Services**]
  - [**Transplants,** including pretransplant evaluations]

The services listed above may not be approved for payment (for example, due to being Experimental, Investigational, Unproven or not Medically Necessary). It is strongly recommended that you request Prior Approval for high-cost services in order to reduce the likelihood of benefits being denied *after* charges are incurred. The complete list of services requiring Prior Approval is subject to review and change by BCBSNM. BCBSNM-contracted Providers have a list of all procedures and services, including individual Surgical Services and injectable drugs, that require Prior Approval. If you need a copy of this list, call a Customer Service representative.]

[IF YOUR PRIOR APPROVAL REQUEST IS DENIED

BCBSNM has established written procedures for reviewing and resolving your concerns. There are 2 different procedures depending on the type of issue involved. This is a summary of the procedures that apply to Prior Approval requests (pre-service claims).

If you are dissatisfied at any time during the review process, you may file an appeal. You may designate a representative to act for you in the review and appeal procedures. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative. If you make an inquiry or request an appeal under the following procedures, you will not be subject to retaliatory action by BCBSNM.

If you have an inquiry or a concern about any Prior Approval request, call your Customer Service representative for assistance. Many complaints or problems can be handled informally by calling or writing BCBSNM Customer Service. If you make an oral complaint, a BCBSNM Customer Service representative will assist you.

Appeal Procedure for Pre-Service Denial

If your request for Prior Approval has been denied in whole or in part, you may appeal the decision and have your request for services reviewed. **Within 180 days** after you receive notice of the decision, call or write to BCBSNM Customer Service and explain your reasons for disagreeing with the adverse determination. You may also ask to see relevant documents and may submit written issues, comments and additional medical information. Requests for review received **more than 180 days** following notification will not be considered unless you can satisfy BCBSNM that matters beyond your control prevented an earlier request for review.

For Urgent Care, BCBSNM follows the "Expedited Review" process. For all other services, BCBSNM follows the "Standard Review" process.

Expedited Review

For urgently needed services, you may request an "expedited review" of your appeal request either orally or in writing. After reviewing your initial Prior Approval request and any additional information you provide in your appeal, BCBSNM will notify you of the decision **within 72 hours** after receiving your appeal request.

Standard Review

After reviewing your initial Prior Approval request and any additional information you provide in your appeal, BCBSNM will notify you of the decision **within 30 days** after receiving your appeal request.

If You Are Still Not Satisfied

If you are still not satisfied with the results of the pre-service appeal decision made by BCBSNM, see [“External Appeal for ERISA Plans”][or “Arbitration for Non-ERISA Plans”][“Arbitration for Non-ERISA Plans”]in *Claim Payment and Appeals.*

ADVANCE BENEFIT INFORMATION

If you want to know what benefits will be paid before receiving services or filing a claim, BCBSNM may require a written request. BCBSNM may also require a written statement from the Provider identifying the circumstances of the case and the specific services that will be provided. An advance confirmation of benefits **does not guarantee** benefits if the actual circumstances of the case differ from those originally described. When submitted, claims are reviewed according to the terms of this Benefit Booklet or any other coverage that applies on the date of service.

UTILIZATION REVIEW/QUALITY MANAGEMENT

Medical records, claims and requests for Covered Services may be reviewed to establish that the services are/were Medically Necessary, delivered in the appropriate setting and consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of BCBSNM's professional consultants. Utilization management decisions are based only on appropriateness of care and service. BCBSNM does not reward Providers or other individuals conducting utilization review for denying coverage or services and does not offer incentives to utilization review decision-makers to encourage underutilization.

HOW YOUR PLAN WORKS

BENEFIT CHOICES

[This benefit program is a Preferred Provider Option (PPO) program that gives you the opportunity to save money, while providing you choice and flexibility when you need medical/surgical care[and Preventive Care Services]. [When you need health care, you have the choice of obtaining benefits from either a Preferred Provider or a Nonpreferred Provider. It's important to understand the differences between them.] When you receive treatment or schedule a Surgery or Admission, ask each of your Providers if he/she is a Preferred Provider. (A Physician's or other Provider's contract may be separate from the Facility's contract.) Your choice can make a difference in the amount you pay and the benefits available to you.]

[Although you can go to the Hospital or Physician of your choice, benefits under the PPO program will be greater when you use the services of a Preferred Provider.]

This benefit program provides benefits under agreement with an exclusive network of Preferred Providers. When you need nonemergency health care that is covered under this benefit program, **you must choose a provider from the Blue Cross and Blue Shield "Preferred Provider Organization (PPO)" network in order to receive benefits.**

PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

Preferred Providers are health care professionals and Facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor or another BCBS Plan as "Preferred" or "PPO" Providers. These Providers have agreed to provide health care for PPO plan Members and accept the plan's payment for a Covered Service plus the Member's share of the Covered Charge (i.e., Deductible, Coinsurance[, Copayment] and/or penalty amount, if any) as payment in full.

Nonpreferred Providers are Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the "Preferred" or "PPO" Provider network. These Providers may have "Participating" Provider agreements, but are **not** considered Preferred.[**Except in an Emergency, services of Nonpreferred Providers are not covered.**]

[When you receive nonemergency medical care, Covered Services must be received from a Provider that has contracted with BCBSNM and/or his/her local Blue Cross and Blue Shield Plan as a Preferred Provider.]

SELECTING A PREFERRED PROVIDER

When you need medical care in New Mexico (or along the border of neighboring states), check the BCBSNM Web site at [**www.bcbsnm.com**] or use the *BCBSNM Preferred Provider Network Directory* to choose a [PPO Primary (PPP) or other]Preferred Provider. Whichever method you use, the directories also list Mental Health Providers (including those specializing in Chemical Dependency)[and Participating Pharmacies].[**Note:** Only those providers listed under Family Practice, General Practice, Internal Medicine, Gynecology, Obstetrics/Gynecology and Pediatrics are considered PPO Primary Providers (PPPs). See "Cost-Sharing Features," later in this section for details.] Although Provider directories are current as of the date shown at the bottom of each page, they can change without notice.

To verify a Provider's current status, request a current directory, request a paper copy of a directory (free of charge) or if you have any questions about the directory, contact a BCBSNM Customer Service representative or visit the BCBSNM Web site at [**www.bcbsnm.com**].

Outside New Mexico

For a list of contracting Providers outside New Mexico, call the BlueCard Doctor and Hospital Information Line at [1-800-810-BLUE (2583)] or visit the BCBSNM Web site at [**www. bcbsnm.com**] which provides links to the listings of Preferred Providers in other states. You can also connect to the national Provider location system at [**www.bcbs.com**]. (If you need Emergency Care, call 911 if necessary or go directly to the nearest emergency room.)

When you call, a BlueCard representative will give you the name and telephone number of a local Provider who will be able to call BCBSNM Customer Service for eligibility information and will submit a claim for the services provided to the local BCBS Plan. Preferred Providers in other states are also eligible for the Preferred Provider level of benefits[, including the PPP office visit Copayment if they are considered "PPO Primary Providers," as defined above].

Out-of-state Providers that contract with their local Blue Cross and/or Blue Shield Plan (BCBS) also accept Covered Charges as payment in full. Please call a BCBSNM Customer Service representative for a list of Preferred Providers with the BCBS Plan in your state (you will be asked for your zip code) or use the Internet to find a Provider near you. **Note:** Providers who have a "Participating-only" contract are **not** Preferred Providers and you will not receive the Preferred Provider benefit level when receiving services from Participating-only Providers. You must use **Preferred Providers** in order to obtain the higher benefit (unless listed under "Benefit Level Exceptions").

[Unsolicited Providers

In some states, the local BCBS Plan does not offer Preferred Provider contracts to certain types of Providers (e.g., Home Health Care Agencies, Chiropractors, Ambulance Providers). These Provider types are referred to as "unsolicited providers." Unsolicited providers vary from state to state. If you receive Covered Services from an "unsolicited provider" outside New Mexico, you will receive the Preferred Provider benefit level for those services. However, the unsolicited provider may still bill you for amounts that are in excess of Covered Charges. You will be responsible for these amounts, in addition to your Deductible and Coinsurance.]

[Exceptions for Nonpreferred Providers

There are three instances in which the services of a Nonpreferred Provider may be eligible for coverage:

- In an **Emergency**, you may visit any emergency room and receive benefits for Covered Services. (See "Emergency and Urgent Care" in *Covered Services* for details.)
- In some states, the local BCBS Plan does not offer Preferred Provider contracts to certain types of Providers (e.g., home health care agencies, chiropractors, ambulance Providers). These Provider types are referred to as "unsolicited providers." The types of Providers that are unsolicited varies from state to state. If you receive Covered Services from an "unsolicited provider" outside New Mexico, you will receive benefits for those services. However, the unsolicited provider may still bill you for amounts that are in excess of Covered Charges, You will be responsible for these amounts, in addition to your Deductible and Coinsurance.
- When you are admitted to a Preferred Hospital or other preferred treatment Facility and the admission is covered under this benefit program, services received during the Admission from a Nonpreferred anesthesiologist, radiologist and/or pathologist will also be covered.

These are the only instances in which the services of a Nonpreferred Provider will be covered.]

BENEFIT PERIOD

[Your Benefit Period is a period of one year which begins on January 1 and ends on December 31 of the same year. The initial Benefit Period is from a Member's Effective Date of Coverage and ends on December 31, which may be less than 12 months.]

[Your Benefit Period is a period of one year which begins on [Month Day] and ends on [Month Day]. The initial Benefit Period is from a Member's Effective Date of Coverage, but ends on the date it would normally end, which may be less than 12 months.]

BENEFIT LIMITATION

[There is no general lifetime maximum benefit under this benefit program.]Certain services have separate benefit limits such as per Admission or per Benefit Period. (See *Benefit Highlights* for details.)

Benefits are determined based upon the coverage in effect on the day a service is received, an item is purchased or a health care expense is incurred. For Inpatient Services, benefits are based upon the coverage in effect on the date of Admission, except that if you are an Inpatient at the time your coverage either begins or ends, benefits for the Admission will be available only for those Covered Services received on and after your Effective Date of Coverage or those received before your termination date.

YOUR DEDUCTIBLE

Your Deductible is the amount of Covered Charges that you must pay in a Benefit Period before this benefit program begins to pay its share of Covered Charges you incur during the same Benefit Period. If the Deductible amount remains

the same during the Benefit Period, you pay it only once each Benefit Period and it applies to all Covered Services you receive during that Benefit Period.

[Individual Deductible]

[There is no Deductible to meet for services of a Preferred Provider.]

[Once a Member's Deductible payments for Nonpreferred Provider services reach the individual Nonpreferred Provider Deductible amount in the *Benefit Highlights*, this benefit program will begin paying its share of that Member's covered Nonpreferred Provider charges.]

[There are 2 individual Deductible amounts indicated in the *Benefit Highlights.* Once a Member's Deductible payments for Preferred Provider services reach the individual Preferred Provider Deductible amount, this benefit program will begin paying its share of that Member's covered Preferred Provider charges. The Member must meet the higher Nonpreferred Provider Deductible before this benefit program begins to pay its share of his/her Covered Charges from Nonpreferred Providers.

Covered Charges for Preferred Provider services are **not** applied to the Nonpreferred Provider Deductible. In addition, Covered Charges for Nonpreferred Providers are **not** applied to the Preferred Provider Deductible.]

[The individual Deductible is listed in the *Benefit Highlights.* Once a Member's Deductible payment for Covered Services reach the individual Deductible amount, this benefit program will begin paying its share of that Member's Covered Charges for the rest of the Benefit Period.]

[Once a Member's Deductible payments reach the individual Deductible amount specified in the *Benefit Highlights*, this benefit program will begin paying its share of that Member's Covered Charges.]

[Family Deductible]

[There is no Deductible to meet for services of a Preferred Provider.]

An entire family meets [the annual Deductible for Nonpreferred Provider services][the applicable annual Deductible][the annual Deductible] when the total Deductible amount for all family members reaches the amount specified in the *Benefit Highlights* (the Deductible amounts for [three or more] family members are combined to satisfy the family Deductible). **Note:** If a Member's individual Deductible is met, no more charges incurred by that Member may be used to satisfy the[applicable] family Deductible.

[An entire family meets the Deductible when the total Deductible amount specified in the *Benefit Highlights*. **Note:** If a Member's individual Deductible is met, no more charges incurred by that Member may be used to satisfy the family Deductible.]

[The Deductible amount you must satisfy depends on whether you have Individual or Family Coverage. An Individual Coverage Member must meet the "Individual Coverage" Deductible before this benefit program begins to pay your Covered Charges, including for items covered under *Prescription Drugs and Other Items*.

An entire family must meet the "Family Coverage" Deductible before this benefit program begins to pay benefits for Covered Services for any covered family member. The Deductible is met when the total Deductible amounts paid by all family members combined reach the amount specified in the *Benefit Highlights*. **Note:** There is no "individual" Deductible to meet for a Member under "Family Coverage." An entire family must first meet the Family Coverage Deductible and one family member may satisfy the entire amount for the whole family.]

What is Not Applied to the Deductible

The following amounts are **not applied** to the Deductible:

- [charges for outpatient Prescription Drugs (see [your *Drug Plan Rider*])]
- [Preferred Provider Copayments]
- [Preferred Provider Coinsurance]
- [PPP office visit Copayments]

- [fixed-dollar Copayments]
- [Mental Health Disorders services]
- [Chemical Dependency services]
- [services covered under the "Heart, Heart-Lung, Liver, Pancreas-Kidney Transplant" provision in *Covered Services*]
- [the first **$**[$100–$1,000] you incur in covered adult Preventive Care Services]
- [Preventive Care Services from Preferred Providers for Dependent children through age 17]

Admissions Spanning Two Benefit Periods

If [the][a] Deductible has been met while you are an Inpatient and the Admission continues into a new Benefit Period, no additional Deductible is applied to that Admission's Covered Services. However, all other services[of a Nonpreferred Provider that are] received during the new Benefit Period are subject to the Deductible[s] for the new Benefit Period.

Timely Filing Reminder

Most benefits are payable only after BCBSNM's records show that the applicable Deductible has been met. Preferred Providers and Providers that have "Participating-only" agreements with BCBSNM will file claims for you and must submit them within a specified amount of time (usually 90 days). If you file your own claims for Covered Services from [Nonparticipating][Nonpreferred] Providers[(see "Exceptions for Nonpreferred Providers," earlier in this section)], you must file them **within 12 months** of the date of service. If a claim is returned for further information, resubmit it **within 45 days.** See *Claim Payments and Appeals* for details.

COST-SHARING FEATURES

[Copayments]

[When you visit a Preferred Provider, the amount you pay is usually a fixed-dollar amount (Copayment). There is no annual Deductible or additional Coinsurance to meet.]

[PPP Office Visit Copayment]

[When you receive **office services** from a **PPP**, you pay only a fixed-dollar amount (or Copayment), for his/her covered **office visit charge**. The Copayment is listed in the *Benefit Highlights.* (No Deductible or additional Coinsurance is required.) However, all other PPP services, including other services received during the office visit, will be subject to the regular Deductible and Coinsurance requirements for Preferred Provider services.[Nonpreferred Providers are not eligible for the "PPP" office visit Copayment, even in an Emergency.]]

[When you receive **office services** from a Preferred Provider, you pay only a fixed-dollar amount (or Copayment), for his/her covered **office visit charge**. (You pay a lower Copayment when visiting a "PPO Primary Provider.") The Copayments for PPO Primary Providers and Specialists are listed in the *Benefit Highlights.* However, all other services, received during the office visit (such as physical therapy or chemotherapy) will be subject to the regular Deductible and Coinsurance requirements and/or to an additional Copayment as listed in the *Benefit Highlights.*

Besides office visits, other services are also subject to a Copayment amount. See the *Benefit Highlights.*]

[***PPO Primary Provider (PPP)*** is a Preferred Provider in one of the following medical specialties **only**: family practice; general practice; internal medicine; obstetrics/gynecology; gynecology; or pediatrics. PPPs do **not** include Physicians specializing in any other fields such as obstetrics only, geriatrics, pediatric Surgery or pediatric allergy.]

Coinsurance

For most Covered Services[received from Nonpreferred Providers (and for specified services received from Preferred Providers)] you must pay a percentage of Covered Charges (Coinsurance) after you have met your annual Deductible. After your share has been calculated, this benefit program pays the rest of the Covered Charge, up to

maximum benefit limits, if any. You pay a lower percentage of Covered Charges when you visit a Preferred Provider.

[Nonpreferred Providers may charge you the difference between the billed charge for a Covered Service and the Covered Charge allowed by BCBSNM – in addition to your Coinsurance and Deductible amount.]

[**Preferred Providers**

When you receive Covered Services from a Preferred Provider, you pay [no][an]annual Deductible[and a percentage of Covered Charges (Coinsurance) after the Deductible is met].[PPP office visit charges are not subject to the Coinsurance or Deductible.][For most Covered Services, you pay only a fixed-dollar Copayment.][(For some services, such as allergy care, Durable Medical Equipment, Prosthetics, orthotics and Medical Supplies, you pay a percentage of the Covered Charge.)][Other services of a PPP and services of a non-PPP Preferred Provider **are** subject to Deductible and Coinsurance.]]

[**Nonpreferred Providers**

When you receive Covered Services from a Nonpreferred Provider,[you must pay an annual Deductible and a percentage of Covered Charges.][you have a higher Deductible amount to meet each year and you must pay a higher percentage of Covered Charges for Nonpreferred Provider services.] The Covered Charge may be less than the billed charge, so you will also be responsible for paying the difference when you receive services from a Nonpreferred Provider.]

Drug Plan

When you purchase covered Prescription Drugs and other items through the drug plan, your responsibility may be either a fixed-dollar amount or a percentage of the Covered Charge. (You may also have to pay the difference between the cost of a Brand-Name Drug and its generic equivalent.) [In either case, drug plan benefits are **not** subject to the Deductible or Out-of-Pocket Limit provisions. See your *Drug Plan Rider* for more information about the amounts you pay under the drug plan.]

[Drugs and other items purchased through the drug plan are subject to the annual Deductible; Coinsurance and/or Copayment amounts you pay for covered items under the drug plan are also applied to the Preferred Provider Out-of-Pocket Limit each Benefit Period. See *Prescription Drugs and Other Items* for more information about the drug plan.]

OUT-OF-POCKET LIMIT

The maximum amount of [Deductible and]Coinsurance[and Copayments] that you pay for most Covered Services in a Benefit Period is your Out-of-Pocket Limit. [There are separate Out-of-Pocket Limits for Preferred Providers and Nonpreferred Providers.] [After the [applicable]Out-of-Pocket Limit is reached, this benefit program pays **100 percent** of most of your Preferred Provider [or Nonpreferred Provider]Covered Charges for the rest of the Benefit Period, not to exceed any benefit limits.]

[The Out-of-Pocket Limit amount that a Member must meet depends on whether you have Individual or Family Coverage. Unlike the Deductible provision, there are **2** separate Out-of-Pocket limits for Preferred Provider and Nonpreferred Provider services. An Individual Coverage Member must meet the applicable "Individual Coverage" Out-of-Pocket Limit before this benefit program begins to pay **100 percent** of his/her Covered Charges for Preferred Provider or Nonpreferred Provider services, as applicable, for the rest of the Benefit Period. The higher Nonpreferred Provider limit must be met before this benefit program pays **100 percent** of most of the Member's Covered Charges for Nonpreferred Provider services.]

[**Individual Limits**]

[Once your Coinsurance[and Deductible][and Copayment] amounts for Preferred Provider services in a Benefit Period reaches the individual Preferred Provider amount indicated in the *Benefit Highlights,* this benefit program pays **100 percent** of most of your covered Preferred Provider charges for the rest of the Benefit Period.]

[Once your Coinsurance[and Copayment] amounts for Nonpreferred Provider services in a Benefit Period reaches the higher individual Nonpreferred Provider amount indicated in the *Benefit Highlights*, this benefit program pays **100 percent** of most of your covered Nonpreferred Provider charges for the rest of the Benefit Period.]

[Once your Coinsurance and Copayment amounts reach the individual amount indicated in the *Benefit Highlights,* this benefit program pays **100 percent** of most of your Covered Charges for the rest of the Benefit Period.]

The Coinsurance [and Copayments]for Preferred Provider services [are][is] **not** applied to the Nonpreferred Provider Out-of-Pocket Limit. In addition, the Coinsurance[and Copayments] for Nonpreferred Providers is not applied to the Preferred Provider Out-of-Pocket Limit.

[**Family Limits**]

[There is no family Out-of-Pocket Limit; each Member must meet his/her own limit in a Benefit Period.]

[An entire family meets the Out-of-Pocket Limit during a Benefit Period when the total Coinsurance [and Copayments]for all family Members reaches the amount specified in the *Benefit Highlights*. (When a Member meets the Out-of-Pocket Limit, no more charges incurred by that Member may be used to satisfy the [applicable] family Out-of-Pocket Limit.)]

[An entire family meets the Out-of-Pocket Limit during a Benefit Period when the total Coinsurance for all family Members reaches the amount specified in the *Benefit Highlights*. (When a Member meets the Out-of-Pocket Limit, no more charges incurred by that Member may be used to satisfy the family Out-of-Pocket Limit.)]

[An entire family must meet the "Family Coverage" Out-of-Pocket Limits indicated in the *Benefit Highlights* before this benefit program begins to pay **100 percent** of Preferred Provider or Nonpreferred Provider Covered Charges for any covered family Member. The applicable limit is met when the total Coinsurance for all family Members reaches the amount specified in the *Benefit Highlights*. **Note:** There are no "individual" limits to meet for a Member under "Family Coverage." An entire family must first meet the Out-of-Pocket Limit(s) and one family Member may satisfy an entire Preferred Provider or Nonpreferred Provider limit for the whole family.]

[The [Copayments and]Coinsurance amounts for Preferred Provider services are **not** applied to the Nonpreferred Provider Out-of-Pocket Limit. In addition, the Coinsurance for Nonpreferred Provider services is not applied to the Preferred Provider Out-of-Pocket Limit.]

What is Not Included in the Out-of-Pocket Limits

The following amounts are **not** applied to the Out-of-Pocket Limits and are **not** eligible for **100 percent** payment under this provision:

- [penalty amounts]
- [amounts in excess of Covered Charges [(including amounts in excess of annual or lifetime benefit limits)]]
- [noncovered expenses (including services in excess of annual or lifetime day/visit limitations)]
- [PPP office visit Copayments]
- [Deductible amounts]
- [Chemical Dependency related services]
- [drug plan Copayments and/or Coinsurance amounts]
- [expenses covered under the "Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney" Transplant provision in *Covered Services* [(There is a separate $[$1,000–$10,000] Out-of-Pocket Limit for certain Transplant-Related Services. See "Transplant Services" in *Covered Services* for details.)]]

[*See the Benefit Highlights for your Deductible amounts,* [*Copayments,*]*Coinsurance percentages and Out-of-Pocket Limit amounts.*]

[*See the Benefit Highlights for Coinsurance percentages and Out-of-Pocket Limit amounts.*]

[EMERGENCY CARE EXCEPTION

If you visit a Nonpreferred Provider for Emergency Care services, the Preferred Provider benefit is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an Emer-

gency, the related Inpatient hospitalization. (Office/Urgent Care Facility services are not considered "emergencies" for purposes of this provision.)

For follow-up care (which is no longer considered an Emergency) and for all other nonemergency care, you will receive the Nonpreferred Provider benefit for the services of a Nonpreferred Provider, even if a Preferred Provider is not available to perform the service. (See "Emergency and Urgent Care" in *Covered Services* for more information.)]

CHANGES TO THE COST-SHARING AMOUNTS

[Coinsurance percentage amounts, Deductibles and Out-of-Pocket Limits may change during a Benefit Period. If changes are made, the change applies only to services received after the change goes into effect. You will be notified if changes are if changes are made to this benefit program.

If your group increases the Deductible or Out-of-Pocket amounts during a Benefit Period, the new amounts must be met during the same Benefit Period. For example, if you have met your Deductible and your group changes to a higher Deductible, you will not receive benefit payments for services received after the change went into effect until the increased Deductible is met.

If your group decreases the Deductible or Out-of-Pocket Limit amount, you will not receive a refund for amounts applied to the higher Deductible or Out-of-Pocket Limit.]

[Coinsurance amounts, [Copayments,]Deductible and Out-of-Pocket Limits may change during a Benefit Period. If changes are made, the change applies only to services received after the change goes into effect. You will be notified if changes are made to this benefit program.

If your Group increases the Deductible or Out-of-Pocket Limit amounts during a Benefit Period, the new amounts must be met during the same Benefit Period. For example, if you have met your Deductible and your Group changes to a higher Deductible, you will not receive benefit payments for services received after the change went into effect until the increased Deductible is met.

If your Group decreases the Deductible or Out-of-Pocket Limit amounts, you will not receive a refund for amounts applied to the higher Deductible or Out-of-Pocket Limit.]

[If you must change from Individual Coverage to Family Coverage because you must add a Dependent to your coverage, you and your new Dependent must meet the higher Family Coverage Deductible and Out-of-Pocket Limit. **Exception:** If you must switch to Family Coverage because of adding an eligible newborn child within the time limits specified in *Enrollment and Termination,* you will not be required to meet the Family Coverage Deductible and Out-of-Pocket Limits for covered Hospital services related to routine newborn nursery care. However, the newborn's pediatrician services for Routine Newborn Care *will* be subject to Family Coverage Deductible and Out-of-Pocket provisions.

If you lose a Dependent and must switch from Family to Individual Coverage, you will be given credit for all amounts applied to both the Family Coverage Deductible and the Family Coverage Out-of-Pocket Limit. However, you will not be given a refund for any amounts that are in excess of the new Individual Coverage amount.

If your employer provided a choice of **2 or more** plan options and you wish to change to a lower or higher Deductible (and Out-of-Pocket Limit), you may do so only during your Group's annual renewal period.]

[BENEFIT LEVEL EXCEPTIONS

Benefits will be provided as indicated in the *Benefit Highlights*, except as listed below.

Emergency Care

If you visit a Nonpreferred Provider for Emergency Care services, [the Preferred Provider benefit is applied only to][you will receive benefits for] the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an Emergency, the related Inpatient hospitalization. (Office/Urgent Care Facility services are not considered "Emergency Care" for purposes of this provision.)

For follow-up care (which is no longer considered Emergency Care) and for all other nonemergency care, you will receive [the Nonpreferred Provider][**no**] benefit for the services of a Nonpreferred Provider, even if a Preferred Provider is not available to perform the service, except as specified below. (See "Emergency and Urgent Care" in *Covered Services* for more information.)

[**Unsolicited Providers**

In some states, the local BCBS Plan does not offer Preferred Provider contracts to certain types of Providers (e.g., Home Health Care Agencies, Chiropractors, Ambulance Providers). These Provider types are referred to as "unsolicited providers." Unsolicited providers vary from state to state. If you receive Covered Services from an "unsolicited provider" outside New Mexico, you will receive the Preferred Provider benefit level for those services. However, the unsolicited provider may still bill you for amounts that are in excess of Covered Charges. You will be responsible for these amounts, in addition to your Deductible and Coinsurance[or Copayment].]

Ancillary Provider Exception

Once you have obtained Prior Approval for an Inpatient Admission to a Preferred Hospital or treatment Facility, your Preferred Physician or Hospital will make every effort to ensure that you receive ancillary services from other Preferred Providers. If you receive Covered Services from a **Preferred** Physician for Outpatient Surgery or Inpatient medical/surgical care in a Preferred Hospital or treatment Facility, services of a nonpreferred radiologist, anesthesiologist or pathologist will be paid at the Preferred Provider level and you will not be responsible for any amounts over the Covered Charge (these are the only three specialties covered under this provision).

If a **nonpreferred** surgeon provides your care or you are admitted to a nonpreferred Hospital or other treatment Facility, you **will** be responsible for [amounts over the Covered Charge for] any services received from Nonpreferred Providers during the Admission or procedure.

Note: Except as described above, the Preferred Provider benefit level will not apply to nonemergency services when received from a Nonpreferred Provider — even if a Preferred Provider is not available in your area to perform the services.]

COVERED SERVICES

This section describes the services and supplies covered by this benefit program, subject to the limitations and exclusions in *How Your Plan Works* and *General Limitations and Exclusions*. All payments are based on Covered Charges as determined by BCBSNM.

[**Reminder:** It is to your financial advantage to receive care from [PPO Primary Providers (PPPs) and other]Preferred Providers.]

MEDICALLY NECESSARY SERVICES

A service or supply is Medically Necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under this benefit program and is determined by BCBSNM's medical director to meet all of the following conditions:

- it is medical in nature;
- it is recommended by the treating Physician;
- it is the most appropriate supply or level of service, taking into consideration:
  - — potential benefits;
  - — potential harms;
  - — cost, when choosing between alternatives that are equally effective; and
  - — Cost Effectiveness, when compared to the alternative services or supplies
- it is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established services or supplies, professional standards and expert opinion may also be taken into account); and
- it is not for the convenience of the Member, the treating Physician, the Hospital or any other health care Provider.

All services must be eligible for benefits as described in this section, not listed as an exclusion and must meet all of the conditions of Medically Necessary in order to be covered.

Note: Because a health care Provider prescribes, orders, recommends or approves a service does not make it Medically Necessary or make it a Covered Service, even if it is not specifically listed as an exclusion. (BCBSNM, at its sole discretion, will determine Medical Necessity based on the criteria above.)

AMBULANCE SERVICES

This benefit program covers Ambulance services in an Emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a nonemergency situation, this benefit program also covers Medically Necessary Ambulance transportation to a Hospital with appropriate facilities or from one Hospital to another.

Air Ambulance

Ground Ambulance is usually the approved method of transportation. This benefit program covers air Ambulance only when terrain, distance or your physical condition requires the use of air Ambulance services or for high-risk Maternity and newborn transport to Tertiary Care Facilities. [To be covered, nonemergency air Ambulance services require **Prior Approval** from BCBSNM.]

BCBSNM determines on a case-by-case basis when air Ambulance is covered. If BCBSNM determines that ground Ambulance services could have been used, benefits are limited to the cost of ground Ambulance services.

Exclusions — This benefit program does **not** cover:

- commercial transport, private aviation or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation or wheelchair Ambulance
- services ordered only because other transportation was not available or for your convenience

DENTAL-RELATED/TMJ SERVICES AND ORAL SURGERY

The following services are the only Dental-Related Services and oral Surgery procedures covered under this benefit program. When alternative procedures or devices are available, benefits are based upon the least costly, medically appropriate procedure or device available.

Dental and Facial Accidents

Benefits for Covered Services for the treatment of Accidental Injuries to the jaw, mouth, face or Sound Natural Teeth are generally subject to the same limitations, exclusions and Member cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, Medical Supplies, Surgical Services).

To be covered, *initial* treatment for the Accidental Injury must be sought **within 72 hours** of the accident. Any services required after the initial treatment must receive [**Prior Approval,** requested **in writing,** from BCBSNM and] be received **within 12 months** of the date of accident in order to be covered. (For treatment of TMJ or CMJ injuries, see "TMJ/CMJ Services.")

Facility Charges

This benefit program covers Inpatient or Outpatient Hospital expenses for Dental-Related Services **only** if the patient is **under age 6** or has a nondental, hazardous physical condition (e.g., heart disease or hemophilia) that makes hospitalization Medically Necessary. All Hospital services for Dental-Related Services must be **prior-approved** by BCBSNM. **Note:** Unless listed as a Covered Service in this section, the Dentist's charges for the procedure will not be covered.

Also, [if you receive services outside New Mexico or]if Hospital services are recommended by a Nonpreferred Provider[in an Emergency], you are responsible for obtaining **Admission review approval** for an Inpatient Admission (or notify BCBSNM **within 48 hours** or as soon as possible for Emergency Care services)[and **Prior Approval** for Outpatient Services to receive maximum benefits]. See *Admission Review and Other Prior Approvals.*

Oral Surgery

This benefit program covers the following oral Surgical Procedures only:

- Medically Necessary orthognathic Surgery [if **Prior Approval** is received from BCBSNM]
- external or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- incision of accessory sinuses, salivary glands or ducts
- lingual frenectomy
- removal or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of mouth when pathological examination is required

TMJ/CMJ Services

This benefit program covers standard diagnostic, therapeutic, Surgical and nonsurgical treatments of Temporomandibular Joint (TMJ) and craniomandibular joint (CMJ) disorders or Accidental Injuries. Treatment may include orthodontic Appliances and treatment, crowns, bridges or dentures **only if** required because of an Accidental Injury to Sound Natural Teeth involving the TMJ or CMJ.

Exclusions — This benefit program does **not** cover oral or dental procedures not specifically listed as covered such as, but not limited to:

- [services that have not been **prior-approved** by BCBSNM (except initial Emergency Care of Accidental Injuries)]
- nonstandard services (diagnostic, therapeutic or surgical)
- removal of tori, exostoses or impacted teeth
- Dental-Related Services that may be related to or required as the result of, a medical condition or procedure (e.g., Chemotherapy or Radiation Therapy)

- procedures involving orthodontic care, the teeth, dental implants, periodontal disease or preparing the mouth for dentures
- duplicate or "spare" appliances
- personalized restorations, Cosmetic replacement of serviceable restorations or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- dental treatment or Surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an Accidental Injury and covered under "Dental and Facial Accidents" or "TMJ/CMJ Services" above
- artificial devices and/or bone grafts for denture wear

[DIABETIC SERVICES

Diabetic persons are entitled to the same benefits for Medically Necessary Covered Services as are other Members under the health care plan. For special coverage details, such as for insulin, glucose monitors and educational services, refer to the applicable provisions as noted below. **Note:** This benefit program will also cover items not specifically listed as covered when new and improved equipment, Appliances and Prescription Drugs for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration.

For insulin and over-the-counter diabetic supplies, see your Drug Plan Rider.

For Durable Medical Equipment, see "Supplies, Equipment and Prosthetics."

For educational services and diabetes management services, see "Physician Visits/Medical Care."]

EMERGENCY CARE AND URGENT CARE

Emergency Care

This benefit program covers Emergency Care which means an Accidental Injury or a condition that occurs suddenly and unexpectedly and is life threatening or could result in permanent damage if not treated immediately. Initial treatment must be sought **within 48 hours** of the accident or onset of symptoms to qualify as an Emergency.

For Accidental Injury to the mouth, jaw, teeth or TMJ, see "Dental-Related/TMJ Services and Oral Surgery."

Use of an emergency center for nonemergency care is NOT covered. However, services will not be denied if you, in good faith and possessing average knowledge of health and medicine, seek care for what reasonably appears to be an Emergency — even if your condition is later determined to be nonemergency.

Acute Emergency Care is available 24 hours per day, 7 days a week. If services are received in an emergency room or other trauma center, the condition and treatment must meet the definition of Emergency Care in order to be covered. Services received in an emergency room that do not meet the definition of Emergency Care may be reviewed for appropriateness and may be denied.

If you visit a Nonpreferred Provider for Emergency Care, the Preferred Provider benefit is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an Emergency, the related Inpatient hospitalization. Once you are discharged, covered follow-up care from a Nonpreferred Provider is [**not covered**][paid at the Nonpreferred Provider benefit level]. (Services received in an office or Urgent Care Facility are not considered Emergency Care for purposes of this provision.)

For all follow-up care (which is no longer considered Emergency Care) and for all other nonemergency care, you will [need to select a Preferred Provider to receive benefits for Covered Services.][receive the Nonpreferred Provider benefit for the Covered Services of a Nonpreferred Provider, even if a Preferred Provider is **not** available to perform the service.]

Admission Notification Within 48 Hours

If you are **admitted** because of a medical Emergency, BCBSNM must be called **within 48 hours** of the Admission with Hospital Admission information [in order to ensure that benefits will be paid correctly.][or benefits for covered Facility services will be reduced by **$**[$100–$1,000]**.**] (See *Admission Review and Other Prior Approvals*.)

[Member Copayments

If you are directly admitted as an Inpatient, the Copayment for emergency room services is waived. The Inpatient Hospital benefit will apply in such cases.]

Urgent Care

This benefit program covers Urgent Care services which means Medically Necessary medical or surgical procedures, treatments or services received for an unforeseen condition that is *not* life-threatening. The condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

[Urgent Care is covered as any other type of service. However, if services are received in an emergency room or other trauma center, the condition and treatment must meet the definition of Emergency Care in order to be covered.]

HOME HEALTH CARE/HOME I.V. SERVICES

For oxygen, ostomy supplies and medical equipment, see "Supplies, Equipment and Prosthetics."

Conditions and Limitations of Coverage

If you are homebound (unable to receive medical care on an Outpatient basis), this benefit program covers Home Health Care Services and home I.V. services [for up to the number of visits specified in the *Benefit Highlights*]. Services must be provided under the direction of a Physician and nursing management must be through a Home Health Care Agency approved by BCBSNM. A *visit* is one period of home health service of up to four hours.

[Prior Approval Required

Before you receive Home Health Care Services or home I.V. therapy, you, your Physician or Home Health Care Agency must obtain **Prior Approval** from BCBSNM. **This benefit program does not cover Home Health Care Services or home I.V. services without Prior Approval.**]

Covered Services

This benefit program covers the following services, subject to the limitations and conditions above, when provided by an approved Home Health Care Agency during a covered visit in your home:

- Skilled Nursing Care provided on an intermittent basis by a Registered Nurse or Licensed Practical Nurse
- Physical, Occupational or Respiratory Therapy provided by licensed or certified Physical, Occupational or Respiratory Therapists
- Speech Therapy provided by an American Speech and Hearing Association certified therapist
- intravenous medications and other Prescription Drugs ordinarily not available through a retail pharmacy [if **Prior Approval** is received from BCBSNM] (If drugs are not provided by the Home Health Care agency, see [your *Drug Plan Rider.)*][*"Prescription Drugs and Other Items.")*]
- laboratory services that would have been covered during an Inpatient Admission
- parenteral and Enteral Nutritional Products that can only be legally dispensed by the written prescription of a Physician and are labeled as such on the packages (If *not* provided by the Home Health Care Agency or if products do not require a prescription, see [your *Drug Plan Rider.*])[*Prescription Drugs and Other Items*.]
- Medical Supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse and temperature

Exclusions — This benefit program does **not** cover:

- care provided primarily for your or your family's convenience

- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to or acting as a sitter for the patient (See the "Custodial Care" exclusion in *General Limitation and Exclusions*.)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- nonprescription Enteral Nutritional Products [(See your *Drug Plan Rider* for details about possible benefits for these products.)][(See *Prescription Drugs and Other Items*.)]

[HOSPICE CARE SERVICES

Conditions and Limitations

This benefit program covers Inpatient and home Hospice services for a Terminally Ill Member received during a Hospice Benefit Period when provided by a Hospice program approved by BCBSNM.[Hospice Care benefits are limited as specified in the *Benefit Highlights.*]

If you need an extension of the Hospice Benefit Period, the Hospice agency must provide a new treatment plan and the attending Physician must recertify your condition to BCBSNM. **No more than 2 Hospice Benefit Periods** will be approved. **Note:** An extension of the Hospice Benefit Period does **not** increase the total amount of benefits payable under this provision.

[Prior Approval Required

Before you receive Hospice Care, you, your attending Physician or the Hospice agency must request **Prior Approval** from BCBSNM. **Hospice Care is not covered without Prior Approval.**]

Covered Services

This benefit program covers the following services, subject to the conditions and limitations above, under the Hospice Care benefit:

- visits from Hospice Physicians
- Skilled Nursing Care by a Registered Nurse or Licensed Practical Nurse
- Physical and Occupational Therapy by licensed or certified Physical or Occupational Therapists
- Speech Therapy provided by an American Speech and Hearing Association certified therapist
- Medical Supplies (If supplies are *not* provided by the Hospice agency, see "Supplies, Equipment and Prosthetics.")
- drugs and medications for the Terminally Ill Patient (If drugs are *not* provided by the Hospice agency, see [your *Drug Plan Rider.*)][*Prescription Drugs and Other Items*.]
- medical social services provided by a qualified individual with a degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience (Such services must be recommended by a Physician to help the Member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a Registered Nurse and in conjunction with Skilled Nursing Care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care for a period **not to exceed 5 continuous days** for **every 60 days** of Hospice Care and **no more than 2 respite care periods** during each Hospice Benefit Period (*Respite care* provides a brief break from total care-giving by the family.)

Exclusions — This benefit program does **not** cover:

- food, housing or delivered meals
- medical transportation
- homemaker and housekeeping services; comfort items

- private duty nursing
- pastoral, spiritual or bereavement counseling
- supportive services provided to the family of a Terminally Ill Patient when the patient is not a Member of this benefit program
- care or services received after the Member's coverage terminates

The following services are **not** Hospice Care benefits but may be covered elsewhere under this benefit program: acute Inpatient Hospital care for curative services, Durable Medical Equipment, Physician visits unrelated to Hospice Care and Ambulance services.]

HOSPITAL/OTHER FACILITY SERVICES

Blood Services

This benefit program covers the processing, transporting, handling and administration of blood and blood components. This benefit program covers directed donor or autologous blood storage fees only when the blood is used during a scheduled Surgical Procedure. This benefit program does **not** cover blood replaced through donor credit.

Inpatient Services

Admission Review Required

If hospitalization is recommended by a Nonpreferred Provider[in an Emergency], **you are responsible** for obtaining Admission approval. If you do not follow the Admission review procedures, benefits for covered Facility services will be **reduced** or **denied** as explained in *Admission Review and Other Prior Approvals.*

Covered Services

For acute Inpatient medical or surgical care received during a covered Hospital Admission, this benefit program covers semiprivate room or Special Care Unit (e.g., ICU, CCU) expenses and other Medically Necessary services provided by the Facility. (If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available. [BCBSNM must give **Prior Approval** for Medically Necessary private room charges to be covered.])

Medical Detoxification

This benefit program also covers Medically Necessary services related to Medical Detoxification from the effects of Alcoholism or Drug Abuse. Detoxification is the treatment in an acute care Facility for withdrawal from the physiological effects of Alcoholism or Drug Abuse, which usually takes about **3 days** in an acute care Facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition. See "Psychotherapy (Mental Health and Chemical Dependency)" for information about benefits for Chemical Dependency rehabilitation.

Outpatient or Observation Services

Coverage for Outpatient or observation services and related Physician or other professional Provider services for the treatment of illness or Accidental Injury depends on the type of service received (for example, see "Lab, X-Ray, Other Diagnostic Services" or "Emergency and Urgent Care").

Exclusions — This benefit program does **not** cover:

- private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws)
- Admissions related to noncovered services or procedures (See "Dental-Related/TMJ Services and Oral Surgery" for an exception.)
- extended care Facility Admissions or Admissions to similar institutions
- Admissions for rehabilitative treatment, such as oxygen therapy (For physical rehabilitation benefits, see "Rehabilitation and Other Therapy.")

LAB, X-RAY, OTHER DIAGNOSTIC SERVICES

For invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see "Surgery and Related Services."

This benefit program covers Diagnostic Services, including but not limited to, preadmission testing, that are related to an illness or Accidental Injury. Covered Services include:

- psychological testing [with **Prior Approval** from [Mesa Mental Health][BCBSNM]]
- x-ray and radiology services, ultrasound and imaging studies
- laboratory and pathology tests
- EKG, EEG and other electronic diagnostic medical procedures
- genetic testing[, with **Prior Approval** from BCBSNM] (Tests such as amniocentesis or ultrasound to determine the sex of an unborn child are not covered; see "Maternity/Reproductive Services and Newborn Care.")
- infertility-related testing[, with **Prior Approval** from BCBSNM] (See "Maternity/Reproductive Services and Newborn Care.")
- PET (Positron Emission Tomography) scans and cardiac CT scans [with **Prior Approval** from BCBSNM]
- home sleep disorder studies[with **Prior Approval** from BCBSNM] (If services must be performed on an Inpatient basis, Admission approval is required.)
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an Accidental Injury or an illness

Note: All services, including those for which Prior Approval is required, must meet the standards of Medical Necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this benefit program. **Some services requiring Prior Approval will not be approved for payment.**

[[MATERNITY/]REPRODUCTIVE SERVICES AND NEWBORN CARE]

Like benefits for other conditions, Member cost-sharing amounts for pregnancy, [family planning,] infertility and newborn care are based on the place of service and type of service received.

[Family Planning and Infertility-Related Services]

[*For oral contraceptive coverage and contraceptive devices purchased from a Pharmacy, see [your Drug Plan Rider.]][Prescription Drugs and Other Items.*]

[Family Planning

Covered family planning services include FDA-approved devices and other procedures such as:

- [injection of Depo-Provera for birth control purposes]
- [diaphragm, including fitting]
- [IUDs or cervical caps, including fitting, insertion and removal]
- [surgical sterilization procedures such as vasectomies and tubal ligations]]

[Infertility-Related Services

This benefit program covers the following infertility-related treatments[when **Prior Approval** is received from BCBSNM] (**Note:** the following procedures only *secondarily* treat infertility):

- [surgical treatments such as opening an obstructed fallopian tube, epididymis or vas when the obstruction is **not** the result of a surgical sterilization]
- [replacement of deficient, naturally occurring hormones **if** there is documented evidence of a deficiency of the hormone being replaced]

The above services are the **only** infertility-related treatments that will be considered for benefit payment.

Infertility *testing,*[when **Prior Approval** is received from BCBSNM,] is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further testing is covered. For example, this benefit program will cover lab tests to monitor hormone levels following the hor-

mone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a noncovered infertility treatment.]

Exclusions — In addition to services not listed as covered above, this benefit program does not cover:

- [contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide]
- [sterilization reversal for males or females]
- [infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization]
- [Gamete Intrafallopian Transfer (GIFT)]
- [Zygote Intrafallopian Transfer (ZIFT)]
- [cost of donor sperm]
- [artificial conception or insemination; fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro (test tube) fertilization and embryo transfer; drugs for induced ovulation; or other artificial methods of conception]]

[Maternity Services

If you are pregnant, you should call BCBSNM before your Maternity due date, soon after your pregnancy is confirmed. If you are admitted to a Nonpreferred Facility[in an Emergency], you are responsible for making sure that BCBSNM is notified **within 48 hours** of Admission for a routine delivery or **within 96 hours** for a C-section delivery (or as soon as possible). If not notified within this time period and your Admission extends beyond **48 hours** or **96 hours** (as applicable), benefits for covered Facility services will be reduced by **$**[$100–$1,000]. See *Admission Review and Other Prior Approvals.*

[A covered Dependent daughter also has coverage for Maternity services. However, if the parent of the newborn is a Dependent child of the Subscriber (i.e., the newborn is the Subscriber's grandchild), benefits are **not** available for the newborn.]

Covered Services

Covered Maternity services include:

- Hospital or other Facility charges for semiprivate room and ancillary services, including the use of labor, delivery and recovery rooms (This benefit program covers all Medically Necessary hospitalization, including **at least 48 hours** of Inpatient care following a vaginal delivery and **96 hours** following a C-section delivery.)
- routine or complicated delivery, including prenatal and postnatal medical care of an obstetrician, Certified Nurse-Midwife or Licensed Midwife (Expenses for prenatal and postnatal care are included in the total Covered Charge for the actual delivery or completion of pregnancy.[The office visit during which a pregnancy is confirmed is subject to the Member cost-sharing provisions that apply to any other office visit.])
- pregnancy-related diagnostic tests, including genetic testing or counseling if **prior approved** by BCBSNM (Services must be sought due to a family history of a sex-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, this benefit program does **not** cover tests such as amniocentesis or ultrasound to determine the sex of an unborn child.)
- necessary anesthesia services by a Provider qualified to perform such services, including Acupuncture used as an anesthetic during a covered Surgical Procedure and administered by a Physician, a licensed Doctor of Oriental Medicine or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available Tertiary Care Facility for newly born infants (See "Ambulance Services" for details.)

- services of a Physician who actively assists the operating surgeon in performing a covered Surgical Procedure when the procedure requires an assistant
- [[elective,]spontaneous or therapeutic termination of pregnancy prior to full term]]

Newborn Care

Covered Services for initial Routine Newborn Care include:

- routine Hospital nursery services, including alpha-fetoprotein IV screening
- routine medical care in the Hospital after delivery
- pediatrician standby care at a C-section procedure
- services related to circumcision of a male newborn

Note: If the parent of the newborn is a Dependent child of the Subscriber (i.e., the newborn is the Subscriber's grandchild), services for the newborn are **not** covered.

For children who are covered from their date of birth, benefits include coverage of injury or sickness, including covered services related to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as required by New Mexico state law.

If both the mother's charges and the baby's charges are eligible for coverage under this benefit program, no additional Deductible[or Hospital Copayment] for the newborn is required for the Facility's initial routine nursery care if the covered newborn is discharged on the same day as the mother.

Extended Stay Newborn Care

A newborn who is enrolled for coverage within the time limits specified in *Enrollment and Termination Information* is also covered if he/she stays in the Hospital longer than the mother.

You must ensure that BCBSNM is called **before** the mother is discharged from the Hospital. If you do not, benefits for the newborn's covered Facility services will be reduced by **$**[$100–$1,000]. The baby's services will be subject to a separate Deductible, Coinsurance[, Hospital Copayment] and Out-of-Pocket Limit.]

PHYSICIAN VISITS/MEDICAL CARE

[Benefits for services received in a Physician's office are based on the type of service received while in the office[and whether the Provider is considered a PPO Primary Provider or a Specialist].]This provision describes benefits for therapeutic injections, allergy care and testing and other nonsurgical, nonroutine medical visits to a health care Provider for evaluating your condition and planning a course of treatment. See specific topics referenced in this section for more information regarding a particular type of service (e.g., *Preventive Care Services*, *Transplant Services*, etc.)

This benefit program covers Medically Necessary care provided by a Physician or other professional Provider for an illness or Accidental Injury. **Your choice of Provider can make a difference in the amount you pay.** (See *How Your Plan Works*.)

Office Visits and Consultations

Services covered under this provision include allergy care, therapeutic injections, office visits, consultations (including second or third surgical opinions) and examinations and other nonroutine office medical procedures — when not related to Hospice Care or payable as part of a Surgical Procedure. (See "Hospice Care" or "Surgery and Related Services" if the medical visits are related to either of these services.)

Allergy Care

This benefit program covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), allergy serum and appropriate FDA-approved allergy injections administered in a Provider's office or in a Facility.[Services must be received from a Preferred Provider in order to be covered.]

Diabetes Self-Management Education

This benefit program covers diabetes self-management training if you have diabetes or an elevated blood glucose due to pregnancy. Training must be prescribed by a health care Provider and given by a certified, registered or licensed health care professional with recent education in diabetes management. For services to be covered,[you must receive **Prior Approval** from BCBSNM]. If approved, Covered Services are limited to:

- Medically Necessary visits upon the diagnosis of diabetes
- visits following a Physician diagnosis that represents a significant change in your symptoms or condition that warrants changes in your self-management
- visits when re-education or refresher training is prescribed by a health care Provider
- medical nutrition therapy related to diabetes management

See [your *Drug Plan Rider*][*Prescription Drugs and Other Items*]for benefits for insulin and oral agents to control blood glucose levels, needles, syringes and test strips; see "Supplies, Equipment and Prosthetics" for other covered supplies and equipment required due to diabetes.

Genetic Inborn Errors of Metabolism

This benefit program covers Medically Necessary expenses related to the diagnosis, monitoring and control of Genetic Inborn Errors of Metabolism. Covered Services include medical assessment, including clinical services, biochemical analysis, Medical Supplies, Prescription Drugs (see [your *Drug Plan Rider*][*Prescription Drugs and Other Items*]*)*, corrective lenses for conditions related to the Genetic Inborn Error of Metabolism, nutritional management and **prior-approved** Special Medical Foods (as described in [your *Drug Plan Rider*][*Prescription Drugs and Other Items*]). In order to be covered, services cannot be excluded under any other provision of this Benefit Booklet and are paid according to the provisions of the benefit program that apply to that particular type of service (e.g., Special Medical Foods are covered under [your *Drug Plan Rider*][*Prescription Drugs and Other Items*], medical assessments under "Physician Visits/Medical Care" and corrective lenses under "Supplies, Equipment and Prosthetics").

To be covered, the Member must be receiving medical treatment provided by licensed health care professionals, including Physicians, dieticians and nutritionists, who have specific training in managing patients diagnosed with Genetic Inborn Errors of Metabolism.

[Injections and Injectable Drugs

This benefit program covers most FDA-approved therapeutic injections administered in a Provider's office.[However, this benefit program covers some injectable drugs only when **Prior Approval** is received from BCBSNM. Your BCBSNM-contracted Provider has a list of those injectable drugs that require Prior Approval. If you need a copy of the list, contact a BCBSNM Health Services representative. (When you request Prior Approval, you may be directed to purchase the self-injectable medication through your drug plan.)]

BCBSNM reserves the right to exclude any injectable drug currently being used by a Member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a BCBSNM Health Services representative if you have any questions about this policy.]

Mental Health Evaluation Services

This benefit program covers medication checks and intake evaluations for Mental Health, Alcoholism and Drug Abuse [when **Prior Approval** is received from [Mesa Mental Health][BCBSNM]]. See "Psychotherapy (Mental Health and Chemical Dependency)" for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits

With the exception of Dental-Related Services (see "Dental-Related/TMJ Services and Oral Surgery"), this benefit program covers the following services when received on a covered Inpatient Hospital day:

- visits for a condition requiring **only** medical care, unless related to Hospice Care (See "Hospice Care Services.")

- consultations (including second opinions) and, if Surgery is performed, Inpatient visits by a Provider who is not the surgeon and who provides medical care **not** related to the Surgery (For the surgeon's services, see "Surgery and Related Services" or "Transplant Services.")
- medical care requiring **2 or more** Physicians at the same time because of multiple illnesses
- initial Routine Newborn Care for a newborn added to coverage within the time limits specified in *Enrollment and Termination Information* (See "Maternity/Reproductive Services and Newborn Care" for details and for extended stay benefits.)

[PRESCRIPTION DRUGS AND OTHER ITEMS

Covered Medications and Other Items

The following drugs, supplies and other products are covered only when dispensed by a Participating Pharmacy under the Retail Pharmacy Program or Specialty Pharmacy Drug Program (unless required as the result of an Emergency) or ordered through the Mail Order Service:

- Prescription Drugs, Medicines and Devices (including compounded medications of which at least one ingredient is a Prescription Drug, prescriptive oral agent for controlling blood sugar levels, insulin, and glucagon and prescription contraceptive medications and prescription contraceptive devices purchased from a Participating Pharmacy), unless listed as an exclusion. (**Note:** Prescription contraceptive devices fitted or inserted by, and purchased directly from a Physician are payable under "Family Planning.")
- Specialty Pharmacy Drugs (such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, Avonex) ([Most injectable drugs require **Prior Approval** from BCBSNM.] Some self-administered drugs, whether injectable or not, are identified as Specialty Pharmacy Drugs and may have to be acquired through a Participating Specialty Pharmacy Drug Provider in order to be covered.)
- insulin needles, syringes and diabetic supplies (e.g., glucagon emergency kits, autolets, lancets lancet devices, blood glucose and visual reading urine and ketone test strips) (A separate Coinsurance amount applies for each item purchased.) These items are not covered as a Medical Supply or medical equipment expense under any medical or surgical provisions of this Benefit Booklet.
- nonprescription Enteral Nutritional Products and Special Medical Foods only when either: 1) delivered through a Medically Necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of Special Medical Foods used to treat and to compensate for the metabolic abnormality of Members with Genetic Inborn Errors of Metabolism in order to maintain their adequate nutritional status
- **2, 90-day courses** of **prior-approved** treatment with FDA-approved Prescription Drugs to assist you with quitting tobacco use or smoking (Starting any course of Prescription Drug therapy counts as one entire course of drug therapy – even if you discontinue or fail to complete the course. Therefore, if you purchase a one-month supply of a Prescription Drug for smoking cessation and do not continue the drug beyond the one month, you have used up one entire 90-day course of treatment with the 30-day supply.)

[Prior Approval Required

Certain Prescription Drugs, injectable medications and Specialty Pharmacy Drugs may require **Prior Approval** from BCBSNM. A list of drugs requiring Prior Approval is available on the BCBSNM Web site at [**www.bcbsnm.com**]. Your Physician can request the necessary Prior Approval.]

Retail Pharmacy/Specialty Pharmacy Drug Program

All items covered under this provision must be purchased from a Participating Retail Pharmacy. **Some drugs may have to be purchased from a Participating Specialty Pharmacy Drug Provider in order to be covered.** (See your Provider directory, call a Customer Service representative or visit the BCBSNM Web site at [**www.bcbsnm.com**] for a list of Participating Pharmacies and Specialty Pharmacy Drug Providers.)

You must present your BCBSNM Identification (ID) Card to the pharmacist at the time of purchase to receive your drug benefits. (You do not receive a separate ID Card; use your BCBSNM ID Card to receive all your medical, surgical and Prescription Drug Covered Services under this benefit program.) Your Coinsurance amounts are listed on your ID Card and in the *Benefit Highlights*.

You can use your ID Card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under this benefit program, the ID Card may not be used to purchase drugs or other items for the terminated member(s). If you do not have your ID Card with you or if you purchase your prescription or other item from a non-Participating Provider in an Emergency, you must pay for the purchase in full and then submit a claim directly to the BCBSNM pharmacy benefit manager. (You should have received the address of the pharmacy benefit manager in the materials you received upon enrollment. If you did not, call Customer Service for the address and a claim form or visit the BCBSNM Web site at [**www.bcbsnm.com**].)

If you are leaving the country or need an extended supply of medication, call Customer Service at least **2 weeks** before you intend to leave. (Extended supplies or vacation overrides are not available through the Mail Order Service (see below) but may be approved only through the Retail Pharmacy Program. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail Pharmacy Program.)

[Mail Order Service

The mail order program offers you the convenience of home delivery at a lower cost per 30-day supply than what you would pay through the retail pharmacy.

Except for supply limitations and nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy/Specialty Pharmacy Drug Provider Program and are subject to the same limitations and exclusions. **Items covered through a Specialty Pharmacy Drug Provider may not be covered through the Mail Order Service.** To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service representative.) **Note:** Prescription Drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved only through the Retail Pharmacy Program.]]

Cost-Sharing Features

For covered Prescription Drugs (including Specialty Pharmacy Drugs), insulin, diabetic supplies, enteral nutritional products and Special Medical Foods, you pay a percentage amount, not to exceed the actual retail price for each Prescription filled or item purchased (not to exceed supply limitations described below). Covered Charges are subject to the overall benefit program Deductible and Preferred Provider Out-of-Pocket Limit provisions (see *Benefit Highlights)*. Once you reach your Preferred Provider Out-of-Pocket Limit, Covered Charges under the drug plan will also be payable at **100 percent** for the rest of the Benefit Period.

When the Coinsurance for an item purchased under the drug plan is greater than the Covered Charge for the supply being purchased from a Participating Pharmacy, you pay the **lesser of**: 1) your Coinsurance amount or 2) the Pharmacy's retail price. For claims submitted to the pharmacy benefit manager for reimbursement, you are paid the **lesser of**: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a Participating Pharmacy and any sales tax minus the applicable Coinsurance amount or 2) the Pharmacy's retail price minus the applicable Coinsurance amount.

Retail Pharmacy and Specialty Pharmacy Drug Supply Limitation

During any 30-day period, for each percentage amount listed in the *Benefit Highlights*, you can obtain up to a **30-day supply** or **180 units** (e.g., pills), whichever is less of a single Prescription Drug or other item covered under this benefit program. If **more than 180 units** are needed to reach a 30-day supply[, **Prior Approval** is required]. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days). For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable percentage amount for a 30-day supply (usually one packaged item).

[Mail Order Service Supply Drug Limitation

During any 90-day period, for each percentage amount listed in the *Benefit Highlights*, you can obtain up to a **90-day supply** or **540 units** (e.g., pills), whichever is less, of a single Prescription Drug or other item covered under the mail order portion of this benefit program. If **less than a 90-day supply** is ordered, percentage amount will still apply. If **more than 540 units** are needed to reach a 90-day supply[, **Prior Approval** is required]. For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable percentage amount for a 90-day supply (usually three packaged items).]

[Minimums and Maximums

For each prescription, you are required to pay a minimum percentage amount up to, but not to exceed, a maximum percentage amount (See *Benefit Highlights*). The following is an example of how the minimum and maximum percentage amounts work when you purchase a Generic Drug through the retail pharmacy program or through the mail order service:

- **Medication A** costs less than $20. You pay the actual retail cost of the prescription.
- **Medication B** costs $40. Since 25% is less than $20, you pay the minimum amount of $20.
- **Medication C** costs $120. Since 25% is greater than $20 and less than $75, you pay 25% (or $30)
- **Medication D** costs $700. Since 25% is greater than $75, you pay the maximum amount of $75.]

Exclusions — Benefits will **not** be provided for:

- nonprescription and over-the-counter drugs unless specifically listed as covered, including herbal or homeopathic preparations and nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or Prescription Drugs that have over-the-counter equivalents (Equivalents have the same strength and cause similar action on bodily tissues.) This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.
- prescriptions or other covered items purchased from a non-Participating Pharmacy, non-Participating Specialty Pharmacy Drug Provider or other Provider unless eligible for benefits in an Emergency situation
- refills before the normal period of use has expired, in excess of the number specified by the Physician or requested **more than one year** following the Physician's original order date (Prescriptions cannot be refilled until **at least 75 percent** of the previously dispensed supply will have been exhausted according to the Physician's instructions. Call Customer Service for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.)
- replacement of drugs or other items that have been lost, stolen, destroyed or misplaced
- [infertility medications]
- [drugs or other items for the treatment of sexual or erectile dysfunction]
- therapeutic devices or appliances, including support garments and other nonmedicinal substances
- medications or preparations used for Cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics), including tretinoin (sold under such brand names as Retin-A) for Cosmetic purposes
- nonprescription Enteral Nutritional Products that are taken by mouth or delivered through a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for Genetic Inborn Errors of Metabolism and the product is prior-approved by BCBSNM); or nonprescription nutritional products that have not been prior-approved by BCBSNM
- shipping, handling or delivery charges
- Prescription Drugs required for international travel or work
- appetite suppressant or diet aids; weight reduction drugs food or diet supplements and medication prescribed for body building or similar purposes]

PREVENTIVE CARE SERVICES

This benefit program covers the following routine physical examinations and associated testing in accordance with national medical standards, the state of New Mexico, the American Academy of Pediatrics and the U.S. Preventive Services Task Force:

- routine physical, breast, pelvic and gynecological examination
- routine adult and pediatric immunizations
- low-dose mammogram screenings (e.g., one baseline mammogram to persons age 40 through 41, one mammogram biennially to persons age 40 through 49 and one mammogram annually to persons age 50 and over), Pap tests and papillomavirus screening
- blood hemoglobin, blood pressure and blood glucose level tests
- blood cholesterol or fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; stool examination for the presence of blood, colonoscopy and glaucoma eye tests
- well-child care as recommended by the American Academy of Pediatrics
- vision and hearing screenings in order to detect the need for additional vision or hearing testing in children **through age 17** when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your Physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being [(Services must receive **Prior Approval** from BCBSNM in order to be covered.)]

The services listed above are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient's age group, such as providing a pediatric immunization to an adult). You and your Physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of your benefit program.

[Children Services (Through Age 17)

Your child Preventive Care Services benefit (for Members **through age 17**) pays covered Preventive Care Services for children at **100 percent** of the Covered Charge,[no Deductible] for Preferred Provider services.[There is no maximum annual benefit for Preferred Provider services.] Nonpreferred Provider Preventive Care Services are subject to the Nonpreferred Provider Deductible and Coinsurance provisions[and are limited to an annual maximum benefit payment of **$**[$100–$1,000] per Member.]]

[Adult Services (Age 18 and Older)

Your adult Preventive Care Services benefit pays covered Preventive Care Services for adults at **100 percent** of the Covered Charges[, no Deductible] for Preferred Provider services[, up to a maximum amount of **$**[$100–$1,000] per Benefit Period.] [After you have reached the **$**[$100–$1,000] limit, benefits for covered Preventive Care Services are subject to the Deductible and Coinsurance provisions.]]

[**Adult Preventive Care Services received from Nonpreferred Providers are not covered.**]

[**Adult Preventive Care Services received from Nonpreferred Providers are not covered.**]

Exclusions — This benefit program does **not** cover:

- employment physicals, insurance examinations or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- immunizations or medications required for international travel
- hepatitis B immunizations when required due to possible exposure during the Member's work
- [routine eye examinations; eye refractions; visual screening for Members over age 17; or any related service or supply]

- [routine hearing examinations; hearing aids; hearing screening for Members over age 17; or any related service or supply]

[PSYCHOTHERAPY (MENTAL HEALTH [AND CHEMICAL DEPENDENCY])

Note: You do not receive a separate Mental Health[/Chemical Dependency] ID Card; use your BCBSNM ID Card to receive all medical/surgical and Mental Health[/Chemical Dependency] services covered under this benefit program.

Medical Necessity

In order to be covered, treatment must be Medically Necessary and not Experimental, Investigational or Unproven. Therapy must be:

- required for the treatment of a distinct Mental Health Disorder as defined by the latest version of the *Diagnostic and Statistical Manual* published by the American Psychiatric Association; and
- reasonably expected to result in significant and sustained improvement in your condition and daily functioning; and
- consistent with your symptoms, functional impairments and diagnoses and in keeping with generally accepted national and local standards of care; and
- provided to you at the least restrictive level of care.

Covered Services/Providers

Covered Services include solution-focused evaluative and therapeutic Mental Health Disorder services (including individual and group psychotherapy) received in Hospitals and other treatment Facilities, an Alcoholism Treatment Program that complies with the Alcohol and Drug Abuse Program standards required by the state of New Mexico and services rendered by psychiatrists, licensed psychologists and Other Providers. See your BCBSNM Provider directory for a list of contracting Providers or check the BCBSNM Web site at [**www.bcbsnm.com.**]

[**Services for the treatment of Mental Health Disorders [and Chemical Dependency] are not covered when received from Nonpreferred Providers.**]

[Prior Approval Required

All psychotherapy must be[**received from a Preferred Provider and**] **prior–approved** by [Mesa Mental Health][BCBSNM]. [If you do not receive Prior Approval for Inpatient Mental Health Disorder services related to Chemical Dependency, benefits for all related services will be denied.] If you do not receive Prior Approval for Inpatient Services[that are not related to Chemical Dependency], benefits for covered Facility services will be **reduced by $**[$100–$1,000]. *Outpatient Services* received without Prior Approval will be **denied**, regardless of diagnosis. See *Admission Review and Other Prior Approvals* for details.

This benefit program also covers electroshock therapy and narcosynthesis when **Prior Approval** is received from [Mesa Mental Health][BCBSNM].]

[Benefit Limits

Benefits for Inpatient and Outpatient[psychotherapy (whether required due to] Mental Health Disorders, Drug Abuse, Alcoholism[or any other covered condition) and related adjunctive] services are limited as specified in the *Benefit Highlights.*]

[Chemical Dependency Benefit Period Limitation

Benefits for Drug Abuse and Alcoholism rehabilitation are limited to those treatments you receive during a maximum of **2, 12-month benefit periods** for as long as you remain covered under the benefit program. Even if you have not exhausted your annual benefit, you will not be extended coverage for Chemical Dependency rehabilitation beyond the **2 benefit periods** to which you are entitled (except as provided for Alcoholism rehabilitation, below). The benefit periods need not be consecutive in order to be covered (as long as you maintain eligibility). Benefits for psychotherapy that is *not* related to Chemical Dependency renew annually and are not subject to a lifetime maximum of benefit periods.]

Minimum Coverage for Alcoholism Rehabilitation

If you exhaust your maximum benefits when receiving services that are *not* related to Alcoholism, you are still entitled to **up to** [30–365] **30 Inpatient days** and [30–365]**30 Outpatient office visits** for Medically Necessary Alcoholism rehabilitation during each of **2, 12-month benefit periods**.[However, if you exhaust an *annual* maximum for psychotherapy services while receiving Alcoholism treatment, benefits for Mental Health Disorders and Drug Abuse will not renew until the following benefit period.] Likewise, if you are receiving Alcoholism treatment and use up the **2 benefit periods**, no further Drug Abuse rehabilitation benefits are available.

Exclusions — This benefit program does **not** cover:

- [care from Nonpreferred Providers]
- [care that has not been **prior-approved** by Mesa Mental Health]
- [care that has not been **prior-approved** by BCBSNM]
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services performed or billed by a school, halfway house or residential treatment Facility, group home, foster care, day treatment, Behavior Modification Services or their staff members
- long-term therapy or therapy for the treatment of chronic Mental Health or incurable conditions for which treatment produces minimal or temporary change or relief – except that medication management for chronic conditions is covered (Chronic conditions are conditions such as, but not limited to, autism, Down's Syndrome and developmental delays. See "Early Developmental Delay and Disability" in *Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- maintenance therapy or care provided after you have reached your rehabilitative potential
- biofeedback, hypnotherapy or behavior modification services
- religious counseling; marital counseling
- custodial care (See the "Custodial Care" exclusion in *General Limitations and Exclusions*.)
- any care that is patient-elected and is not considered Medically Necessary
- charges that are mandated by court order or as a legal alternative and lacks clinical necessity as diagnosed by a licensed Provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest Mental Health Disorders or other disturbances (See "Early Developmental Delay and Disability" in *Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- non-national standard therapies, including those that are Experimental as determined by the Mental Health professional practice
- the cost of any damages to a treatment Facility
- charges associated with any episode of Alcoholism or Drug Abuse for which you did not complete the prescribed continuum of care
- [care in excess of the annual or lifetime maximum benefits specified in the *Benefit Highlights*]

REHABILITATION AND OTHER THERAPY

When billed by a Facility during a covered Admission, therapy is covered in the same manner as the other ancillary services (see "Hospital/Other Facility Services").

[Acupuncture and Spinal Manipulation

This benefit program covers Acupuncture and spinal manipulation services when administered by a licensed Provider acting within the scope of licensure and when necessary for the treatment of an illness or Accidental Injury. Benefits for Acupuncture and spinal manipulation are limited as specified in the *Benefit Highlights*. **Services must be received from a Preferred Provider in order to be covered.**]

This benefit program does **not** cover these services when received from Nonpreferred Providers.

Cardiac and Pulmonary Rehabilitation

This benefit program covers Outpatient Cardiac Rehabilitation programs provided **within 6 months** of a cardiac incident and Outpatient Pulmonary Rehabilitation services. [**Prior Approval** must be obtained from BCBSNM or benefits will be denied.][**Services must be received from a Preferred Provider in order to be covered.**]

[This benefit program does **not** cover these services when received from Nonpreferred Providers.]

Chemotherapy and Radiation Therapy

This benefit program covers the treatment of malignant disease by standard Chemotherapy and treatment of disease by Radiation Therapy. [**High-dose Chemotherapy treatments must receive Prior Approval from BCBSNM in order to be covered.**]

Cancer Clinical Trials

If you are a participant in a phase II, III or IV approved Cancer Clinical Trial that is being conducted in New Mexico, you may receive coverage for certain Routine Patient Care Costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention and be designed to study the reoccurrence, early detection or treatment of cancer. The persons conducting the trial must provide BCBSNM with notice of when the Member enters and leaves a qualified Cancer Clinical Trial.

The Routine Patient Care Costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved Prescription Drugs that are not paid for by the manufacturer, distributor or supplier of the drug. (Member cost-sharing provisions described under [*your Drug Plan Rider*][*Prescription Drugs and Other Items*] will apply to these benefits.)

If benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

Dialysis

This benefit program covers the following services when received from a Dialysis Provider [or when **Prior Approval** is received from BCBSNM in your home]:

- renal Dialysis (hemodialysis)
- continual ambulatory peritoneal Dialysis (CAPD)
- apheresis and plasmapheresis
- the cost of equipment rentals and supplies for home Dialysis

Short-Term Rehabilitation: Occupational, Physical, Speech Therapy ([Inpatient and]Outpatient[, Including Skilled Nursing Facility])

[Prior Approval Required

To be covered, all [Inpatient,] [Outpatient,] [office] and [home-based] Short-Term Rehabilitation treatments[, including Skilled Nursing Facility and physical rehabilitation Facility Admissions,] must receive **Prior Approval** from BCBSNM[and be received from a **Preferred Provider**]. Short-Term Rehabilitation required due to reinjury or aggravation of an injury is also covered but must receive a separate **Prior Approval** from BCBSNM, even if therapy was authorized for the original injury.]

Covered Services

This benefit program covers the following Short-Term Rehabilitation services when rendered [by a **Preferred Provider**] for the Medically Necessary treatment of Accidental Injury or illness:

- Occupational Therapy performed by a licensed Occupational Therapist
- Physical Therapy performed by a Physician, licensed Physical Therapist or other professional Provider licensed as a Physical Therapist (such as a Doctor of Oriental Medicine or Chiropractor)

- [joint and spinal manipulation services when administered by a licensed Provider acting within the scope of licensure and when necessary for the treatment of an Accidental Injury or medical condition]
- Speech Therapy, including audio diagnostic testing, performed by a properly accredited Speech Therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly or a previous treatment or therapy
- [Inpatient physical rehabilitation and Skilled Nursing Facility services]

[Benefit Limits

Benefits for all [Inpatient,][Outpatient,] [office] and[home-based] therapies[combined] are limited as specified in the *Benefit Highlights.*]

Conditions of Coverage

To be eligible for benefits, therapies must meet the following conditions:

- Services must be[received from **Preferred Providers** and] **Prior Approved** by BCBSNM.
- There is a documented condition or delay in recovery that can be expected to measurably improve with therapy **within 2 months** of beginning active therapy.
- Improvement would not normally be expected to occur without intervention.

Exclusions—This benefit program does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this benefit program does **not** cover services that exceed maximum benefit limits, if any. See the "Long-Term or Maintenance Therapy" exclusion in *General Limitations and Exclusions.)*
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay (Chronic conditions are conditions, such as, but not limited to, autism, Down's Syndrome and developmental delays. See "Early Developmental Delay and Disability" in *Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- diagnostic, therapeutic, rehabilitative or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- [private room expenses]
- Speech Therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family or caregiver/teacher
- long-term therapies, even if you have not yet used or exhausted maximum benefits, if any (See the "Long-Term and Maintenance Therapy" exclusion in *General Limitations and Exclusions.*)
- herbs, homeopathic preparations or nutritional supplements
- [Acupuncture (For benefit for Acupuncture used as an anesthetic during a covered surgical procedure, see "Surgery and Related Services.")]
- services of a massage therapist or rolfing

[SMOKING/TOBACCO USE CESSATION

This benefit program covers smoking and tobacco use cessation treatment, limited to the following diagnostic and counseling services [received from **Preferred Providers**][and drug therapy that has been prior-approved by BCBSNM] (subject to Member cost-sharing provisions applicable to the type of service received, such as [Prescription Drugs,] counseling, etc.):

- Diagnostic Services to identify tobacco use, use-related conditions and dependence
- **2, 90-day courses** of **prior-approved** treatment with FDA-approved Prescription Drugs to assist you with quitting tobacco use or smoking (See[your *Drug Plan Rider*][*Prescription Drugs and Other Items*] for benefit details.)

- a choice of Cessation Counseling of **up to 90 minutes** total Provider contact time or **2 multi-session group programs** per Benefit Period (Covered counseling is restricted to programs that meet minimum requirements established by the NM Public Regulation Commission; see *Definitions* for minimum Cessation Counseling requirements.)

Starting any course of [Prescription Drug therapy or]Cessation Counseling constitutes one entire course of[drug therapy or] Cessation Counseling – even if you discontinue or fail to complete the course. [For example, if you purchase a one-month supply of a Prescription Drug for smoking cessation and do not continue the drug beyond one month, you will have used up one entire 90-day course of treatment with the 30-day supply.]

To locate a Provider that is approved to provide Cessation Counseling sessions, you may call BCBSNM Customer Service[, Mesa Mental Health] or ask your personal Physician[about obtaining a prescription for smoking cessation drugs].

Exclusions — This benefit program does **not** cover the following services:

- [Cessation Counseling or treatment received from Nonpreferred Providers or drug therapy that has not received Prior Approval]
- Acupuncture, biofeedback or hypnotherapy for smoking/tobacco use cessation
- over-the-counter tobacco cessation products, including but not limited to items such as nicotine patches or nicotine gum [(See[your *Drug Plan Rider*][*the Benefit Highlights and Prescription Drugs and Other Items*]for Copayments and other limitations that apply to Prescription Drugs.)]]

SUPPLIES, EQUIPMENT AND PROSTHETICS

For contraceptive devices, see "Maternity/Reproductive Services and Newborn Care: Family Planning."

For supplies or equipment used during an Inpatient or Outpatient stay, see "Hospital/Other Facility Services." (Supplies or equipment that are dispensed by a Facility for use outside of the Facility are subject to the provisions of "Supplies, Equipment and Prosthetics.")

If you have a question about Durable Medical Equipment, Medical Supplies, Prosthetics or Appliances not listed, please call the BCBSNM Health Services Department.

[**Prior Approval** from BCBSNM is required for:

- **specific items** listed in this section
- **long-term rental** of an item
- when total charges for an item equal **$500**[$100–$1,000] **or more** *(Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use.)]

Diabetic Supplies and Equipment

Under this provision, this benefit program covers the following supplies and equipment for diabetic Members and individuals with elevated glucose levels due to pregnancy (supplies are not to exceed a **30-day supply** purchased during any 30-day period):

- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps [if Prior Approval is received from BCBSNM] and insulin pump supplies
- blood glucose monitors, including those for the legally blind
- Medically Necessary podiatric Appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics that have been **prior-approved** by BCBSNM, custom molded inserts, replacement inserts, preventive devices and shoe modifications

Reminder: [Prior Approval is required for items costing **over $500**[$100–$1,000] or requiring long-term rental.] For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips for glucose monitors, glucagon emergency kits) see[*your Drug Plan Rider*][*Prescription Drugs and Other Items*].

Note: The benefit program will also cover items not specifically listed as covered when new and improved equipment, Appliances and Prescription Drugs for the treatment and management of diabetes are approved by the U.S.

Food and Drug Administration. This benefit program will: 1) maintain an adequate formulary to provide these resources to individuals with diabetes; and 2) guarantee reimbursement or coverage for the equipment, Appliances, Prescription Drugs, insulin or Medical Supplies described in this Benefit Booklet[and/or your *Drug Plan Rider*] within the limits of this benefit program.

Benefits for diabetic supplies and equipment are not subject to the Supplies and Durable Medical Equipment limitation listed in the *Benefit Highlights*.

Durable Medical Equipment and Appliances

This benefit program covers the following items [(Prior Approval is required for items costing **over $500**[$100–$1,000] or requiring long-term rental)]:

- Orthopedic Appliances [(**Prior Approval** is required, regardless of total cost)]
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, Hospital beds, crutches and other Medically Necessary Durable Medical Equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intraocular Surgery or ocular injury, to treat conditions related to Genetic Inborn Errors of Metabolism or prescribed by a Physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a Physician or Optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers
- the rental of (or at the option of BCBSNM, the purchase of) Durable Medical Equipment (including repairs to such purchased items), when prescribed by a covered health care Provider and required for therapeutic use

[**Note:** [Benefits for Durable Medical Equipment received from a **Nonpreferred Provider** are limited each Benefit Period to the amount indicated in the *Benefit Highlights*. (The limitation does not apply to diabetic equipment, oxygen or oxygen equipment.)][Benefits for Durable Medical Equipment received from a Preferred Provider are not limited.][**This benefit program does not cover Durable Medical Equipment received from a Nonpreferred Provider.**]]

Medical Supplies

This benefit program covers the following Medical Supplies, not to exceed a **30-day supply** purchased during any 30-day period, unless otherwise indicated:

- colostomy bags, catheters
- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports when billed by a Physician or other Provider during a covered office visit
- slings
- support hose prescribed by a Physician for treatment of varicose veins[([2–12] pair per Benefit Period)]

[**Note:** [Benefits for Medical Supplies received from a **Nonpreferred Provider** are limited each Benefit Period to the amount indicated in the *Benefit Highlights*. (The limitation does not apply to diabetic equipment, oxygen or

oxygen equipment.)][Benefits for Medical Supplies received from a Preferred Provider are not limited.][**This benefit program does not cover Medical Supplies received from a Nonpreferred Provider.**]]

Orthotics and Prosthetic Devices

When Medically Necessary and ordered by a Provider, this benefit program covers the following items:

- surgically implanted Prosthetics or devices, including penile implants required as a result of illness or Accidental Injury[, if **Prior Approval** for such items is received from BCBSNM]
- externally attached Prosthetics to replace a limb or other body part lost after Accidental Injury or surgical removal; their fitting, adjustment, repairs and replacement
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast Prosthetics when required as the result of a mastectomy
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle or leg (A functional orthotic is used to control the function of the joints and is covered only when **prior-approved by BCBSNM** and prescribed by a Physician or Podiatrist.)

When alternative Prosthetic Devices are available, the allowance for a Prosthesis will be based upon the least costly item.

[**Note:** [Benefits for orthotics and Prosthetics received from a **Nonpreferred Provider** are limited each Benefit Period to the amount indicated in the *Benefit Highlights*.[(The limitation does not apply to breast Prosthetics or mastectomy bras, which are limited to [2–12] **bras** per Benefit Period.)][Benefits for Prosthetics and orthotics received from a Preferred Provider are not limited.][**This benefit program does not cover orthotics and Prosthetics received from a Nonpreferred Provider**.]]

Exclusions — This benefit program does **not** cover, regardless of therapeutic value, items such as, but not limited to:

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts or beds; external Prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling or skiing
- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables or telephone arms
- repair costs that exceed the rental price of another unit for the estimated period of need or repair or rental costs that exceed the purchase price of a new unit
- dental Appliances (See “Dental-Related/TMJ Services and Oral Surgery” for exceptions.)
- [accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities and provide comfort, but do not alter function)]
- orthopedic shoes, unless joined to braces (Diabetic Members may be eligible to receive benefits for these items. Call BCBSNM Health Services for details.)
- equipment or supplies not ordered by a health care Provider, including items used for comfort, convenience or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft or destruction
- voice synthesizers or other communication devices
- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints or other extra features for eyeglasses or contact lenses

- hearing aids or ear molds, fitting of hearing aids or ear molds or related services or supplies (For surgically implanted devices for the profoundly hearing impaired, see "Surgery and Related Services.")
- stethoscopes or blood pressure monitors
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under [your *Drug Plan Rider*][*Prescription Drugs and Other Items*).]
- items that can be purchased over-the-counter, including but not limited to dressings for bed sores and burns, gauze and bandages
- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide (See "Maternity/Reproductive Services and Newborn Care: Family Planning" for devices requiring a prescription.)
- items not listed as covered
- [costs for items received from a Nonpreferred Provider that exceed the maximum benefit listed in the *Benefit Highlights*]

SURGERY AND RELATED SERVICES

For Accidental Injuries to the jaws, mouth or teeth, oral Surgery or treatment of TMJ disorders or injuries, see "Dental-Related/TMJ Services and Oral Surgery."

See "Maternity/Reproductive Services and Newborn Care" for deliveries, C-sections, surgical sterilizations and limited infertility-related treatments or "Transplant Services," if applicable.

You are responsible for obtaining Admission review[and/or other Prior Approval] when necessary (see *Admission Review and Other Prior Approvals*).

Surgeon's Services

Covered Services include surgeon's charges for a covered Surgical Procedure.

Cochlear Implants

This benefit program covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device. [You must submit a **written request for Prior Approval** to BCBSNM before treatment begins.][This benefit program does **not** cover cochlear implant services without Prior Approval.]

Mastectomy Services

This benefit program covers Medically Necessary hospitalization related to a covered mastectomy (including **at least 48 hours** of Inpatient care following a mastectomy and **24 hours** following a lymph node dissection).

This benefit program also covers Cosmetic breast Surgery, when **prior-approved** by BCBSNM and received **within 12 months** of a mastectomy for breast cancer (unless a later Surgical Procedure is approved as medically appropriate by BCBSNM). Coverage is limited to:

- Cosmetic Surgery of the breast/nipple on which the mastectomy was performed, including tattooing procedures;
- the initial Surgery of the other breast to produce a symmetrical appearance;
- prostheses and treatment of physical complications following the mastectomy, including treatment of lymphedema.

[This benefit program does **not** cover subsequent procedures to correct unsatisfactory Cosmetic results attained during the initial breast/nipple Surgery or tattooing or breast Surgery that has not received Prior Approval from BCBSNM.]

Reconstructive Surgery

Reconstructive Surgery improves or restores bodily function to the level experienced before the event that necessitated the Surgery or in the case of a congenital defect, to a level considered normal. Such Surgeries may

have a coincidental Cosmetic effect. This benefit program covers Reconstructive Surgery when required to correct a **functional** disorder caused by:

- an Accidental Injury
- a disease process or its treatment (For breast Surgery following a mastectomy, see "Mastectomy Services," above.)
- a functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects)

[You or your Physician must obtain **Prior Approval, requested in writing,** from BCBSNM **before** the reconstructive service is provided.] [If the procedure (including any reconstructive service listed under "Dental-Related/TMJ Services and Oral Surgery") has not received Prior Approval, **the Surgery and all related charges will be denied.**] Cosmetic procedures and procedures that are not Medically Necessary, including all services related to such procedures, will also be **denied.**

Exclusions — This benefit program does **not** cover:

- Cosmetic or plastic Surgery or procedures, such as breast augmentation, rhinoplasty and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under "Mastectomy Services")
- procedures to correct Cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy or any procedure to correct visual refractive defect
- unless required as part of Medically Necessary diabetic disease management, trimming of corns, calluses, toenails or bunions (except surgical treatment such as capsular or bone Surgery)
- sex change operations or complications arising from transsexual Surgery
- subsequent Surgical Procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ Transplant, sex change operation or previous Cosmetic Surgery)
- [obesity treatment, including the surgical treatment of morbid obesity]
- [any reconstructive procedure, orthognathic Surgery, cochlear implant, breast reduction, orthotripsy or Cosmetic breast Surgery that has not received Prior Approval from BCBSNM]
- the insertion of artificial organs or services related to Transplants not specifically listed as covered under "Transplant Services"
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby Physician actually assists

Anesthesia Services

This benefit program covers necessary anesthesia services, including Acupuncture used as an anesthetic, when administered during a covered Surgical Procedure by a Physician, certified Registered Nurse anesthetist (CRNA), a licensed Doctor of Oriental Medicine (for Acupuncture) or other practitioner as required by law.[(See "Rehabilitation and Other Therapy" for information about Acupuncture benefits.)]

Exclusions — This benefit program does **not** cover local anesthesia. (Coverage for Surgical Procedures includes an allowance for local anesthesia because it is considered a routine part of the Surgical Procedure.)

Assistant Surgeon Services

Covered Services include services of a professional Provider who actively assists the operating surgeon in the performance of a covered Surgical Procedure when the procedure requires an assistant.

Exclusions — This benefit program does **not** cover:

- services of an assistant only because the Hospital or other Facility requires such services
- services performed by a resident, intern or other salaried employee or person paid by the Hospital

- services of more than one assistant surgeon unless the procedure is identified by BCBSNM as requiring the services of more than one assistant surgeon

TRANSPLANT SERVICES

Prior Approval, requested in writing, must be obtained from BCBSNM **before** a pretransplant evaluation is scheduled. A pretransplant evaluation is **not** covered if Prior Approval is not obtained from BCBSNM. If approved, a BCBSNM case manager will be assigned to you (the Transplant recipient candidate) and must later be contacted with the results of the evaluation.

If you are approved as a Transplant recipient candidate, you must ensure that **Prior Approval** for the actual Transplant is also received. None of the benefits described here are available unless you have this Prior Approval.

Facility Must Be in Transplant Network

Benefits for Covered Services will be approved only when the Transplant is performed at a Facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan or the national BCBS Transplant network, for the Transplant being provided. Your BCBSNM case manager will assist your Provider with information on the exclusive network of contracted Facilities and required approvals. Call BCBSNM Health Services for information on these BCBSNM Transplant programs.

Effect of Medicare Eligibility on Coverage

If you are now eligible for (or are *anticipating* receiving eligibility for) Medicare benefits, **you** are solely responsible for contacting Medicare to ensure that the Transplant will be eligible for Medicare benefits.

Organ Procurement or Donor Expenses

If a Transplant is covered, the surgical removal, storage and transportation of an organ acquired from a cadaver is also covered. If there is a living donor that requires Surgery to make an organ available for a covered Transplant, coverage is available for expenses incurred by the donor for Surgery, organ storage expenses and Inpatient follow-up care only.

This benefit program does **not** cover donor expenses after the donor has been discharged from the Transplant Facility. Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected.

Bone Marrow, Cornea or Kidney

This benefit program covers the following Transplant procedures if **Prior Approval** is received from BCBSNM:

- bone marrow Transplant for a Member with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID) or Wiskott-Aldrich syndrome and other conditions for which it is determined by BCBSNM to be Medically Necessary and not Experimental, Investigational or Unproven
- cornea Transplant
- kidney Transplant

Covered Services related to the above Transplants are subject to the usual cost-sharing features and benefit limits of this benefit program (e.g., Deductible, Coinsurance[, Copayments] and Out-of-Pocket Limits; annual Home Health Care maximums).

Reminder: A Transplant received at a Facility that does not directly or indirectly contract with BCBSNM to provide Transplant services is not covered.

Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney

This benefit program also covers Transplant-Related Services for a **heart, heart-lung, liver, lung or pancreas-kidney** Transplant. Services must be **prior-approved** in order to be covered. Also, all other limitations, requirements and exclusions of this "Transplant Services" provision apply to these Transplant-Related Services. In addition, the following provisions apply to this coverage for **one year** following the date of the actual Transplant or

retransplant. After one year, usual benefits apply and the services must be covered under other provisions of the benefit program in order to be considered for benefit payment.

[**Recipient Travel and Per Day Expenses**

If BCBSNM requires you (i.e., the Transplant recipient) to temporarily relocate outside of your city of residence to receive a covered Transplant, travel to the city where the Transplant will be performed will be covered. Also, a standard per day benefit as indicated in the *Benefit Highlights* will be allowed for food and lodging expenses for one additional adult traveling with you (the Transplant recipient). If the Transplant recipient is a Dependent child under the age of 18, benefits for travel and per day expenses for **2 adults** to accompany the child are available.

[Travel expenses and standard per day allowances are limited to a combined maximum amount as indicated in the *Benefit Highlights*. Your case manager may approve travel and per day food and lodging allowances based upon the total number of days of temporary relocation, up to the benefit maximum indicated in the *Benefit Highlights*.]

[Travel expenses are **not** covered and per day allowances are **not** paid if you *choose* to travel to receive a Transplant for which travel is not considered Medically Necessary by the case manager or if the travel occurs **more than 5 days** before or **more than one year** following the Transplant or retransplant date.]]

Cost-Sharing Features

Covered Services under this "Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney" provision are subject to the cost-sharing features as indicated in the *Benefit Highlights* [and a separate **per Transplant** Out-of-Pocket Limit (After the [Copayments and]Coinsurance for services related to a single Transplant reaches the separate Transplant Out-of-Pocket Limit all further services related to the Transplant and received **within one year** of the Transplant will be paid at **100 percent** of Covered Charges, up to maximum benefit amounts, if any.).[There is also no Deductible to meet.] If you need a retransplant, these cost-sharing provisions renew starting from the date of the retransplant procedure.]

Reminder: A Transplant received at a Facility that does **not** contract directly or indirectly with BCBSNM to provide Transplant services is not covered.

Transplant Exclusions— This benefit program does **not** cover:

- any Transplant or organ-combination Transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart); nonhuman organ Transplants
- care for complications of noncovered Transplants or follow-up care related to such Transplants
- services related to a Transplant that did not receive Prior Approval from BCBSNM
- services related to a Transplant performed in a Facility not contracted directly or indirectly with BCBSNM to provide the required Transplant
- expenses incurred by a Member of this plan for the donation of an organ to another person
- drugs that are self-administered or for use while at home [(These services may be covered under your drug plan.)]
- donor expenses after the donor has been discharged from the Transplant Facility
- lodging, food, beverage or meal expenses in excess of the per day allowance, if available
- travel or per day expenses:
  - — incurred **more than 5 days before** or **more than one year following** the date of transplantation
  - — if the recipient's case manager indicates that travel is not Medically Necessary
  - — related to a bone marrow, cornea or kidney Transplant
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)

- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family or from any other person charging for transportation that does not ordinarily do so)

PRESCRIPTION DRUGS AND OTHER ITEMS

COVERED MEDICATIONS AND OTHER ITEMS

The following drugs, supplies and other products are covered only when dispensed by a Participating Pharmacy under the Retail Pharmacy Program or Specialty Pharmacy Drug Program (unless required as the result of an Emergency) or ordered through the Mail Order Service:

- Prescription Drugs, Medicines and Devices (including compounded medications of which at least one ingredient is a Prescription Drug, prescriptive oral agent for controlling blood sugar levels, insulin, and glucagon[and prescription contraceptive medications and prescription contraceptive devices]purchased from a Participating Pharmacy), unless listed as an exclusion.[(**Note:** Prescription contraceptive devices fitted or inserted by, and purchased directly from a Physician are payable under "Family Planning.")]
- Specialty Pharmacy Drugs (such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, Avonex) ([Most injectable drugs require **Prior Approval** from BCBSNM.] Some self-administered drugs, whether injectable or not, are identified as Specialty Pharmacy Drugs and may have to be acquired through a Participating Specialty Pharmacy Drug Provider in order to be covered.)
- insulin needles, syringes and diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet devices blood glucose and visual reading urine and ketone test strips) (A separate Copayment or Coinsurance amount applies for each item purchased.) These items are not covered as a Medical Supply or medical equipment expense under any medical or surgical provisions of this Benefit Booklet.
- nonprescription Enteral Nutritional Products and Special Medical Foods only when either: 1) delivered through a Medically Necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of Special Medical Foods used to treat and to compensate for the metabolic abnormality of Members with Genetic Inborn Errors of Metabolism in order to maintain their adequate nutritional status
- **2, 90-day** courses of **prior–approved** treatment with FDA-approved Prescription Drugs to assist you with quitting tobacco use or smoking (Starting any course of Prescription Drug therapy counts as one entire course of drug therapy – even if you discontinue or fail to complete the course. Therefore, if you purchase a one–month supply of a Prescription Drug for smoking cessation and do not continue the drug beyond the one month, you have used up one entire 90-day course of treatment with the 30-day supply.)

[Prior Approval Required

Certain Prescription Drugs, injectable medications and Specialty Pharmacy Drugs may require **Prior Approval** from BCBSNM. A list of drugs requiring Prior Approval is available on the BCBSNM Web site at [**www.bcbsnm.com**]. Your Physician can request the necessary Prior Approval.]

RETAIL PHARMACY/SPECIALTY PHARMACY DRUG PROGRAM

All items covered under this provision must be purchased from a Participating Retail Pharmacy. **Some drugs may have to be purchased from a Participating Specialty Pharmacy Drug Provider in order to be covered.** (See your Provider directory, call a Customer Service representative or visit the BCBSNM Web site at [**www.bcbsnm.com**] for a list of Participating Pharmacies and Specialty Pharmacy Drug Providers.)

You must present your BCBSNM Identification (ID) Card to the pharmacist at the time of purchase to receive your drug benefits. (You do not receive a separate ID Card; use your BCBSNM ID Card to receive all your medical, surgical and Prescription Drug Covered Services under this benefit program.) Your Copayment and/or Coinsurance amounts are listed on your ID Card[and in the *Benefit Highlights*].

You can use your ID Card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under this benefit program, the ID Card may not be used to purchase drugs or other items for the terminated family member(s). If you do not have your ID Card with you or if you purchase your Prescription or other item from a non-Participating Pharmacy Provider in an Emergency, you must pay for the purchase in full and then submit a claim directly to the BCBSNM pharmacy benefit manager. (You should have received the address of the pharmacy benefit manager in the materials you received upon enrollment. If you did not, call Customer Service for the address and a claim form or visit the BCBSNM Web site at [**www.bcbsnm.com**].)

If you are leaving the country or need an extended supply of medication, call Customer Service **at least 2 weeks** before you intend to leave.[(Extended supplies or vacation overrides are not available through the Mail Order Service (see below) but may be approved only through the Retail Pharmacy Program. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail Pharmacy Program.)]

[MAIL ORDER SERVICE

The mail order program offers you the convenience of home delivery at a lower cost per 30-day supply than what you would pay through the Retail Pharmacy Program.

Except for supply limitations and nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy and are subject to the same limitations and exclusions. **Items covered through a Specialty Pharmacy Drug Provider may not be covered through the Mail Order Service.** To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service representative.) **Note:** Prescription Drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved only through the Retail Pharmacy Program.]

COST-SHARING FEATURES

[For covered Prescription Drugs (including Specialty Pharmacy Drugs), insulin, diabetic supplies, enteral nutritional products and Special Medical Foods, you pay a not to exceed the actual retail price for each Prescription filled or item purchased (not to exceed supply limitations described below). Covered Charges are subject to the overall benefit program Deductible and Preferred Provider Out-of-Pocket Limit provisions (see *Benefit Highlights)*. Once you reach your Preferred Provider Out-of-Pocket Limit, Covered Charges under the drug plan will also be payable at **100 percent** for the rest of the Benefit Period.]

[For covered Prescription Drugs (including Specialty Pharmacy Drugs), insulin, diabetic supplies and nutritional products, you pay either a Copayment or Coinsurance amount, not to exceed the actual retail price, for each Prescription filled or item purchased (not to exceed supply limitations described below). **See your ID Card** or the *Benefit Highlights* **for your Copayment/Coinsurance amounts.** Copayment/Coinsurance amounts are **not** subject to a Deductible, are **not** included in any Out-of-Pocket Limit and are **not** eligible for reimbursement once an Out-of-Pocket Limit is reached. You may also have to pay the difference in cost between a Brand-Name Drug and its generic equivalent (see below).][BluePPO][BluePPO Options][BluePPO Plus][BlueNet][BlueEdge HCA]

[When the Coinsurance for an item purchased under the drug plan is greater than the Covered Charge for the supply being purchased from a Participating Pharmacy, you pay the **lesser of**: 1) your Coinsurance amount or 2) the Pharmacy's retail price. For claims submitted to the pharmacy benefit manager for reimbursement, you are paid the **lesser of**: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a Participating Pharmacy and any sales tax minus the applicable Coinsurance amount or 2) the Pharmacy's retail price minus the applicable Coinsurance amount.]

[When either the Copayment or the Coinsurance for an item purchased under the drug plan is greater than the Covered Charge for the supply being purchased from a Participating Pharmacy, Specialty Pharmacy Drug Provider or contracted mail order service vendor, you pay the **lesser of**: 1) your Copayment or Coinsurance amount or 2) the Pharmacy's or Vendor's retail price. For claims submitted to the pharmacy benefit manager for reimbursement, you are paid the **lesser of**: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a Participating Pharmacy and any sales tax minus the applicable Copayment or Coinsurance amount or 2) the Pharmacy's retail price minus the applicable Copayment or Coinsurance amount.]

[Retail Pharmacy and Specialty Pharmacy Drug Supply Limitation]

[During any 30-day period, for each listed in the *Benefit Highlights*, you can obtain up to a **30-day supply** or **180 units** (e.g., pills), whichever is less of a single Prescription Drug or other item covered under this benefit program. [If **more than 180 units** are needed to reach a 30-day supply, **Prior Approval** is required.] For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days). For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable percentage amount for a 30-day supply (usually one packaged item).]

[During any 30-day period, for each Copayment or Coinsurance amount listed in the *Benefit Highlights*, you can obtain up to a **30-day supply** or **180 units** (e.g., pills), whichever is less of a single Prescription Drug or other item covered under this benefitEWF National Accounts program. [If **more than 180 units** are needed to reach a 30-day

supply, **Prior Approval** is required.] For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days). For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable Copayment or Coinsurance amount for a 30-day supply (usually one packaged item).]

[Mail Order Service Supply Drug Limitation]

[During any 90-day period, for each listed in the *Benefit Highlights*, you can obtain up to a **90-day supply** or **540 units** (e.g., pills), whichever is less, of a single Prescription Drug or other item covered under the mail order portion of this benefit program. If **less than a 90-day supply** is ordered, will still apply.[If **more than 540 units** are needed to reach a 90-day supply, **Prior Approval** is required.] For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable percentage amount for a 90-day supply (usually 3 packaged items).]

[During any 90-day period, for each Copayment or Coinsurance amount listed in the *Benefit Highlights*, you can obtain up to a **90-day supply** or **540 units** (e.g., pills), whichever is less, of a single Prescription Drug or other item covered under the mail order portion of this benefit program. If **less than a 90-day supply** is ordered, the applicable Copayment or Coinsurance amount will still apply.[If **more than 540 units** are needed to reach a 90-day supply, **Prior Approval** is required.] For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable Copayment or Coinsurance amount for a 90-day supply (usually 3 packaged items).]

[Minimums and Maximums

For each prescription, you are required to pay a minimum percentage amount up to, but not to exceed, a maximum percentage amount (See *Benefit Highlights*). The following is an example of how the minimum and maximum percentage amounts work when you purchase a Generic Drug through the retail pharmacy program or through the mail order service:

— **Medication A** costs less than $20. You pay the actual retail cost of the prescription.

— **Medication B** costs $40. Since 25% is less than $20, you pay the minimum amount of $20.

— **Medication C** costs $120. Since 25% is greater than $20 and less than $75, you pay 25% (or $30)

— **Medication D** costs $700. Since 25% is greater than $75, you pay the maximum amount of $75.]

Exclusions — Benefits will **not** be provided for:

- nonprescription and over-the-counter drugs unless specifically listed as covered, including herbal or homeopathic preparations and nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or Prescription Drugs that have over-the-counter equivalents (Equivalents have the same strength and cause similar action on bodily tissues.) This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.
- prescriptions or other covered items purchased from a non-Participating Pharmacy, non-Participating Specialty Pharmacy Drug Provider or other Provider unless eligible for benefits in an Emergency situation
- refills before the normal period of use has expired, in excess of the number specified by the Physician or requested **more than one year** following the Physician's original order date (Prescriptions cannot be refilled until **at least 75 percent** of the previously dispensed supply will have been exhausted according to the Physician's instructions. Call Customer Service for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.)
- replacement of drugs or other items that have been lost, stolen, destroyed or misplaced
- [infertility medications]
- [drugs or other items for the treatment of sexual or erectile dysfunction]
- therapeutic devices or appliances, including support garments and other nonmedicinal substances
- medications or preparations used for Cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics), including tretinoin (sold under such brand names as Retin-A) for Cosmetic purposes
- nonprescription Enteral Nutritional Products that are taken by mouth or delivered through a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for Genetic

Inborn Errors of Metabolism and the product is prior-approved by BCBSNM); or nonprescription nutritional products that have not been prior-approved by BCBSNM

- shipping, handling or delivery charges
- Prescription Drugs required for international travel or work
- appetite suppressant or diet aids; weight reduction drugs food or diet supplements and medication prescribed for body building or similar purposes

[BRAND-NAME DRUG VERSUS GENERIC DRUG COSTS

If you or the Provider request the Brand-Name Drug when there is an FDA-approved generic equivalent available, you must pay the difference in cost between the Brand-Name Drug and its Generic equivalent, plus the Generic Drug Member Copayment or Coinsurance amount.]

[BRAND-NAME EXCLUSION

Some equivalent drugs are manufactured under multiple brand names. In such cases, BCBSNM may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under this benefit program, the Brand-Name Drug purchased will not be covered under any benefit level.]

[FILING CLAIMS

Claims for items covered under the drug plan must be sent to the pharmacy benefit manager — not to BCBSNM. If not included in your enrollment materials, you can obtain the name and address of the pharmacy benefit manager and claim forms from a Customer Service representative or on the BCBSNM Web site at [**www.bcbsnm.com**].]

GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** services listed in this Benefit Booklet[and your *Drug Plan Rider*].

This benefit program does not cover any service or supply not specifically listed as a Covered Service in this Benefit Booklet. If a service is not covered, then all services performed in conjunction with it are not covered.

This benefit program will not cover any of the following services, supplies, situations or related expenses:

— [**Acupuncture**

This benefit program may not cover acupuncture unless used as an anesthetic during a covered surgical procedure.]

— [**Admissions/Treatments Discontinued by Patient**

This benefit program may not cover charges associated with any episode of Alcoholism or Drug Abuse for which the patient did not complete the prescribed continuum of care.]

— **Before Effective Date of Coverage**

This benefit program does not cover any service received, item purchased, prescription filled or health care expense incurred before your Effective Date of Coverage. If you are an Inpatient when coverage either begins or ends, benefits for the Admission will be available only for those Covered Services received on and after your Effective Date of Coverage or those received before your termination date.

— **Biofeedback**

This benefit program does not cover services related to biofeedback.

— **Blood Services**

This benefit program does not cover directed donor or autologous blood storage fees when the blood is used during a nonscheduled Surgical Procedure. **This benefit program does not cover** blood replaced through donor credit.

— **Complications of Noncovered Services**

This benefit program does not cover any services, treatments or procedures required as the result of complications of a noncovered service, treatment or procedure (e.g., due to a noncovered sex change operation, Cosmetic Surgery, Transplant or Experimental procedure).

— **Convalescent Care or Rest Cures**

This benefit program does not cover convalescent care or rest cures.

— **Cosmetic Services**

Cosmetic Surgery is beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic. **This benefit program does not cover** Cosmetic Surgery, services or procedures for psychiatric or psychological reasons or to change family characteristics or conditions caused by aging. **This benefit program does not cover** services related to or required as a result of a Cosmetic Service, procedure, Surgery or subsequent procedures to correct unsatisfactory Cosmetic results attained during an initial Surgery.

Examples of Cosmetic procedures are: dermabrasion; revision of surgically induced scars; breast augmentation; rhinoplasty; surgical alteration of the eye; correction of prognathism or micrognathism; excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, legs or buttock; services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body including, but not limited to, breast, face, lips, jaw, chin, nose, ears or genitals; or any procedures that BCBSNM determines are not required to materially improve the physiological function of an organ or body part.

Exception: Cosmetic breast/nipple Surgery required due to a mastectomy may be covered. However, **Prior Approval, requested in writing,** must be obtained from BCBSNM for such services. Also, prior-approved

reconstructive Surgery, which may have a coincidental Cosmetic effect, may be covered when required as the result of Accidental Injury, illness or congenital defect. See "Surgery and Related Services" in *Covered Services* for details.

— Custodial Care

This benefit program does not cover custodial care or care in a place that is primarily your residence when you do not require Skilled Nursing Care. **This benefit program does not cover** services to assist in activities of daily living (such as sitter's or homemaker's services) or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished or by whom they were recommended.

— Dental-Related/TMJ Services and Oral Surgery

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Dental-Related/TMJ Services and Oral Surgery" in *Covered Services* for additional exclusions.

— Domiciliary Care

This benefit program does not cover domiciliary care or care provided in a residential institution, treatment center, halfway house or school because your own home arrangements are not available or are unsuitable and consisting chiefly of room and board, even if therapy is included.

— Duplicate (Double) Coverage

This benefit program does not cover amounts already paid by Other Valid Coverage or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare and had claimed Medicare benefits. See *Coordination of Benefits and Subrogation* for more information. Also, if your prior coverage has an extension of benefits provision, **this benefit program will not cover** charges incurred after your Effective Date of Coverage under this benefit program that are covered under the prior plan's extension of benefits provision.

— Duplicate Testing

This benefit program does not cover duplicative diagnostic testing or overreads of laboratory, pathology or radiology tests.

— Experimental, Investigational or Unproven Services

This benefit program does not cover any treatment, procedure, Facility, equipment, drug, device or supply not accepted as standard medical practice or those considered Experimental, Investigational or Unproven. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is Experimental and will not be covered. To be considered Experimental, Investigational or Unproven, one or more of the following conditions must be met:

- The device, drug or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug or medicine is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

The guidelines and practices of Medicare, the FDA or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.

Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same medical treatment, procedure, device or drug; or the written informed consent used by

the treating Facility or by another Facility studying substantially the same medical treatment, procedure, device or drug. Experimental or Investigational does not mean cancer Chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

The service must be Medically Necessary and not excluded by any other contract exclusion.

Standard medical practice means the services or supplies that are in general use in the medical community in the United States and:

- have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or other Facility Provider in which they were performed; and
- the Physician or other professional Provider has had the appropriate training and experience to provide the treatment or procedure.

— Food or Lodging Expenses

This benefit program does not cover food or lodging expenses, except for those that are eligible for a per day allowance under the "Transplant Services" in *Covered Services* and not excluded by any other provision in this section.

— Genetic Testing or Counseling

This benefit program does not cover genetic counseling or testing, unless the testing has received **Prior Approval** from BCBSNM. See "Maternity/Reproductive Services and Newborn Care" in *Covered Services* for details. **This benefit program does not cover** tests such as amniocentesis or ultrasound to determine the sex of an unborn child.

— Hair Loss Treatments

This benefit program does not cover wigs, artificial hairpieces, hair Transplants or implants or medication used to promote hair growth or control hair loss, even if there is a medical reason for hair loss.

— [Hearing Examinations, Procedures and Aids

This benefit program does not cover audiometric (hearing) tests unless: 1) required for the diagnosis and/or treatment of an Accidental Injury or an illness or 2) covered as a preventive *screening* service for children through age 17. (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) **This benefit program does not cover** hearing aids and ear molds, fitting of hearing aids or ear molds or any related service or supply. (For surgically implanted devices, see "Surgery and Related Services" in *Covered Services.*)]

— Home Health, Home I.V. and Hospice Services

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Home Health Care/Home I.V. Services" or "Hospice Care" in *Covered Services* for additional exclusions.

— Hypnotherapy

This benefit program does not cover hypnosis or services related to hypnosis, whether for medical or anesthetic purposes.

— [Infertility Services/Artificial Conception

This benefit program does not cover services related to, but not limited to, procedures such as: [artificial conception or insemination,] [fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro ("test tube") fertilization,] [Gamete Intrafallopian Transfer (GIFT),] [Zygote Intrafallopian Transfer (ZIFT),] [embryo transfer, drugs for induced ovulation] or other artificial methods of conception. **This benefit program does not cover** the cost of donor sperm, costs associated with the collection, preparation or storage of sperm for artificial insemination or donor fees.]

[**This benefit program does not cover** infertility testing, treatments or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization.] **This benefit program**

does not cover reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see "Maternity/Reproductive Services and Newborn Care" in *Covered Services*.)]

— Late Claim Filing

This benefit program does not cover services of a Nonparticipating Provider if the claim for such services is received by BCBSNM **more than 12 months** after the date of service. (Preferred Providers and Providers that have a Participating-only agreement with BCBSNM will file claims for you and must submit them within a specified period of time, usually 90 days.) See "Filing Claims" in *Claim Payments and Appeals* for details.

— Learning Deficiencies/Behavioral Problems

This benefit program does not cover special education, counseling, therapy, diagnostic testing, treatment or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance. (See *Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)

— Limited Services/Covered Charges

This benefit program does not cover amounts in excess of Covered Charges or services that exceed any maximum benefit limits listed in this Benefit Booklet or any amendments, riders, addenda or endorsements.

— Local Anesthesia

This benefit program does not cover local anesthesia. (Coverage for surgical, Maternity, diagnostic and other procedures includes an allowance for local anesthesia because it is considered a routine part of the procedure.)

— Long-Term and Maintenance Therapy

This benefit program does not cover long-term therapy, even if Medically Necessary and even if any applicable benefit maximum has not yet been reached. (Therapies are considered long-term if measurable improvement is not possible **within 2 months** of beginning active therapy.) **Note:** This exclusion does **not** apply to benefits for medication or medication management.

This benefit program does not cover maintenance therapy or care or any treatment that does not significantly improve your function or productivity or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved Hospice Benefit Period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your Physician supporting his/her opinion. **Note:** Even if your rehabilitative potential has not yet been reached, **this benefit program does not cover** services that exceed maximum benefit limits.

— Medical Policy Determinations

Any technologies, procedures or services for which Medical Policies have been developed by BCBSNM are either limited or excluded as defined in the Medical Policy.

— Medically Unnecessary Services

This benefit program does not cover services that are not Medically Necessary as defined in *Covered Services* unless such services are specifically listed as covered (e.g., see "Preventive Services" in *Covered Services*).

BCBSNM determines whether a service or supply is Medically Necessary and whether it is covered. Because a Provider prescribes, orders, recommends or approves a service or supply does *not* make it Medically Necessary or make it a Covered Service, even if it is not specifically listed as an exclusion. (BCBSNM, at its sole discretion, determines Medical Necessity based on the criteria given in *Covered Services*.)

— No Legal Payment Obligation

This benefit program does not cover services for which you have no legal obligation to pay or that are free, including:

- charges made only because benefits are available under this benefit program
- services for which you have received a professional or courtesy discount

- volunteer services
- services provided by you for yourself or a covered family member, by a person ordinarily residing in your household or by a family member
- Physician charges exceeding the amount specified by Centers for Medicare & Medicaid Services (CMS) when primary benefits are payable under Medicare

Note: The "No Legal Payment Obligation" exclusion does not apply to services received at Department of Defense facilities or covered by Indian Health Service/Contract Health Services, Medicaid or certain services that are reimbursed to the Department of Health according to the "Early Developmental Delay and Disability" provision in *Claim Payments and Appeals.*

— Noncovered Providers of Service

This benefit program does not cover services prescribed or administered by a:

- member of your immediate family or a person normally residing in your home
- Physician, other person, supplier or Facility (including staff members) that are not specifically listed as covered in this Benefit Booklet, such as a:
  - — health spa or health fitness center (whether or not services are provided by a licensed or registered Provider)
  - — school infirmary
  - — halfway house
  - — massage therapist
  - — private sanitarium
  - — extended care Facility or similar institution
  - — Residential Treatment Center (A Residential Treatment Center is a Facility where the primary services are the provision of room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization.)
  - — dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee or any similar person or group
  - — pain clinic or any Provider primarily in the practice of pain management or treatment

— Nonmedical Expenses

This benefit program does not cover nonmedical expenses (even if medically recommended and regardless of therapeutic value), including costs for services or items such as, but not limited to:

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see "Physician Visits/Medical Care" and "Preventive Services" in *Covered Services* for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; get-acquainted visits without physical assessment or medical care; telephone consultations; provision of medical information to perform Admission review or other Prior Approvals; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs or other such facilities
- personal convenience items such as air conditioners, humidifiers, exercise equipment or personal services such as haircuts, shampoos, guest meals and television rentals

- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a Hospice Admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the Member's work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment Facility that are caused by the Member
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education

— [**Nonpreferred Provider Services**

This benefit program does not cover the following services when received from a Nonpreferred Provider: Acupuncture, spinal manipulation, [smoking/tobacco use Cessation Counseling,]Outpatient Cardiac and Pulmonary Rehabilitation, Inpatient or Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, Skilled Nursing Facility services, Inpatient or Outpatient psychotherapy and Transplants.]

— [**Nonpreferred Provider Services**

This benefit program does not cover the following services when received from a Nonpreferred Provider: Acupuncture, spinal manipulation, Outpatient Cardiac and Pulmonary Rehabilitation, Inpatient or Outpatient Physical Therapy, adult Preventive Care Services, Speech Therapy, Occupational Therapy, [smoking/tobacco use Cessation Counseling,] Skilled Nursing Facility services, Inpatient or Outpatient psychotherapy and Transplants.]

— [**Nonpreferred Provider Services**

This benefit program does not cover services of a Nonpreferred Provider unless listed as a benefit exception in *How Your Plan Works*.

— **Nonprescription Drugs**

This benefit program does not cover nonprescription or over-the-counter drugs, medications, ointments or creams, including herbal or homeopathic preparations or Prescription Drugs that have over-the-counter equivalents, except for those products specifically listed as covered [in your *Drug Plan Rider*][*under Prescription Drugs and Other Items*]. (Equivalents have the same strength and cause similar action on bodily tissues.) This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.

— **Nutritional Supplements**

This benefit program does not cover vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk or diets, unless prescribed by a Physician. Such supplements must require a prescription to be covered under the "Home Health Care/Home I.V. Services" in *Covered Services.* [This benefit program covers other nutritional products only under specific conditions set forth under [your *Drug Plan Rider*][*Prescription Drugs and Other Items*.]

— [**Obesity Treatment**

This benefit program does not cover surgical, dietary or medical treatment of obesity under any circumstance.]

— **Post-Termination Services**

This benefit program does not cover any service received or item or drug purchased after your coverage is terminated, even if: 1) Prior Approval for such service, item or drug was received from BCBSNM or 2) the service, item or drug was needed because of an event that occurred while you were covered. If you are an Inpatient when coverage ends, benefits for the Admission will be available only for those Covered Services received before your termination date.

— [**Preexisting Conditions**

This benefit program does not cover [any Preexisting Conditions for up to [3–6] **months** following the Member's Initial Enrollment Eligibility date.][A Late Applicant accepted for coverage is not covered for Preexisting Conditions for up to [6–18] **months** following his/her Effective Date of Coverage.] See "Preexisting Conditions Limitation" in *Enrollment and Termination Information*.]

— [**Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products and Special Medical Foods**

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see *Prescription Drugs and Other Items* for additional exclusions.]

— **Prior Approval Not Obtained When Required**

This benefit program does not cover certain services if you do not obtain Prior Approval from BCBSNM before those services are received. See *Admission Review and Other Prior Approvals.*

— [**Private Duty Nursing Services**

This benefit program does not cover private duty nursing services.]

— **Private Room Expenses**

This benefit program does not cover private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns and conditions that require isolation according to public health laws). Private room charges must be **prior-approved** by BCBSNM to be covered.

— **Sex-Change Operations and Services**

This benefit program does not cover services related to sex-change operations, reversals of such procedures or complications arising from transsexual Surgery.

— **Sexual Dysfunction Treatment**

This benefit program does not cover services related to the treatment of sexual dysfunction.

— **Supplies, Equipment and Prosthetics**

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Supplies, Equipment and Prosthetics" in *Covered Services* for additional exclusions.

— **Surgery and Related Services**

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Surgery and Related Services" in *Covered Services* for additional exclusions.

— **Therapy and Counseling Services**

This benefit program does not cover therapies and counseling programs other than the therapies listed as covered in this Benefit Booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this section, see "Rehabilitation and Other Therapy" in *Covered Services* for additional exclusions. **This benefit program does not cover** services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sex and Z therapies
- self-help, stress management[, weight-loss] and codependency programs

- [smoking/tobacco use Cessation Counseling programs of Preferred Providers that do not meet the standards set by the NM Public Regulation Commission [or that are received from Nonpreferred Providers]
- services of a massage therapist or rolfing
- transactional analysis, encounter groups and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, religious or marital counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a Member of this benefit program
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay (See "Early Developmental Delay and Disability" in *Claim Payments and Appeals* for coverage of certain services provided to eligible children by the Department of Health.)
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)

— Thermography

This benefit program does not cover thermography (a technique that photographically represents the surface temperatures of the body).

— TMJ/CMJ Services

This benefit program does not cover nonstandard diagnostic, therapeutic or surgical TMJ/CMJ treatments. **This benefit program does not cover** orthodontic appliances and treatment, crowns, bridges or dentures for TMJ/CMJ treatments unless required as the result of an Accidental Injury to the TMJ/CMJ.

— Transplant Services

Please see "Transplant Services" in *Covered Services* for specific Transplant services that are covered and related limitations and exclusions. In addition to services excluded by the other general limitations and exclusions listed throughout this section, **this benefit program does not cover** any other Transplants (or organ-combination Transplants) or services related to any other Transplants.

— Travel or Transportation

This benefit program does not cover travel expenses, even if travel is necessary to receive Covered Services unless such services are eligible for coverage under "Transplant Services" or "Ambulance Services" in *Covered Services*.

— Veteran's Administration Facility

This benefit program does not cover services or supplies furnished by a Veterans Administration facility for a service-connected disability or while a Member is in active military service.

— Vision Services

This benefit program does not cover any services related to refractive keratoplasty (Surgery to correct near-sightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct visual refractive defect (e.g., farsightedness or astigmatism). **This benefit program does not cover** eyeglasses, contact lenses, prescriptions associated with such procedures and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered under "Supplies, Equipment and Prosthetics" in *Covered Services.* **This benefit program does not cover** sunglasses, special tints or other extra features for eyeglasses or contact lenses.

— War-Related Conditions

This benefit program does not cover any service required as the result of any act of war or related to an illness or Accidental Injury sustained during combat or active military service.

— [**Weight Management**

This benefit program does not cover weight-loss or other weight-management programs, dietary control or surgical or medical obesity treatment.]

— **Work-Related Conditions**

This benefit program does not cover services resulting from work-related illness or injury or charges resulting from occupational accidents or sickness covered under:

- occupational disease laws
- employer's liability
- municipal, state or federal law (except Medicaid)
- Workers' Compensation Act

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (BCBSNM may pay claims during the appeal process on the condition that you sign a reimbursement agreement.)

This benefit program does not cover a work-related illness or injury, **even if:**

- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care not authorized by Workers' Compensation insurance.
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for an employee's work-related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

Note: This "Work-Related Conditions" exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation who has affirmatively elected not to accept the provisions of the New Mexico Workers' Compensation Act. You must provide documentation showing that you have waived Workers' Compensation and are eligible for the waiver. (The Workers' Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

COORDINATION OF BENEFITS (COB)

This benefit program contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are enrolled in any Other Valid Coverage, the combined benefit payments from all coverages **cannot exceed 100 percent** of BCBSNM's Covered Charges.

If you are also covered by Medicare, special COB rules may apply. Contact a Customer Service representative for more information. If you are enrolled in federal continuation coverage, coverage ends at the beginning of the month when you become entitled to Medicare or when you become insured under any Other Valid Coverage (unless a Preexisting Condition limitation applies).

When this benefit program is secondary, all provisions (such as obtaining Prior Approval) must be followed or benefits may be denied or reduced.

For a work-related injury or condition, see "Work-Related Conditions" exclusion in General Limitations and Exclusions.

The following rules determine which coverage pays first:

1. **No COB Provision** — If the Other Valid Coverage does not include a COB provision, that coverage pays first.
2. **Medicare** — If the Other Valid Coverage is Medicare and Medicare is not secondary according to federal law, Medicare pays first.
3. **Subscriber/Dependent** — If a Member is covered as the Subscriber under one coverage and as a dependent under another, the Subscriber's coverage pays first. **Exception:** If Medicare is secondary to the plan of an *active* worker covering the Medicare beneficiary as a dependent, then that plan determines its benefits first then Medicare and last, the plan covering the Medicare beneficiary as the Subscriber.

   If you have Other Valid Coverage *and* Medicare, contact the other carrier's customer service department to find out if the other coverage is primary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may not be subject to those provisions.
4. **Dependent Child** — For a Dependent child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year pays first. If the Other Valid Coverage does not follow this rule, the father's coverage pays first.
5. **Dependent Child, Parents Separated or Divorced** — For a Dependent child of divorced or separated parents, benefits are coordinated in the following order:
   - *Court-Decreed Obligations.* Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.
   - *Custodial/Noncustodial.* The plan of the custodial parent pays first. The plan of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.
   - *Joint Custody.* If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the child, the plans follow the rules that apply to children whose parents are not separated or divorced.
6. **Active/Inactive Employee** — If a Member is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. (Even if a Member is covered as a dependent under both coverages, the coverage through active employment pays first.) If the other plan does not have this rule and the plans do not agree on the order of benefits, the next rule applies.
7. **Longer/Shorter Length of Coverage** — When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of benefits, a change in the entity that pays, provides or administers the benefits or a change from one type of plan to another.)

Responsibility For Timely Notice

BCBSNM is not responsible for coordination of benefits if timely information is not provided.

Facility of Payment

Whenever any other plan makes benefit payments that should have been made under this benefit program, BCBSNM has the right to pay the other plan any amount BCBSNM determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this benefit program and with that payment BCBSNM will fully satisfy its liability under this provision.

Overpayments

Regardless of who was paid, whenever benefit payments made by BCBSNM exceed the amount necessary to satisfy the intent of this provision, BCBSNM has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan, or any other organizations or persons.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your possible right to COBRA continuation coverage, which is a temporary extension of coverage under this benefit program. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for certain larger Group employers. COBRA continuation coverage may be available to you and to other members of your family who are covered under the benefit program when you would otherwise lose your Group health coverage. Contact your employer to determine if you or your Group are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage;
- When it may become available to you and your family if your Group is subject to the provisions of COBRA; and
- What you need to do to protect your right to receive it.

This notice gives only a summary of COBRA continuation coverage rights. For more information about the rights and obligations under the plan and under federal law, contact the Plan Administrator or see *Enrollment and Termination Information* of this Benefit Booklet.

The Plan Administrator of the plan is named by the employer or by the Group Health Care Plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA Administrator for specific information for your plan.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens and if your Group is subject to the provisions of COBRA:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- The parents become divorced or legally separated; or

- The child stops being eligible for coverage under the Plan as a dependent child.

If the plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retiree covered under the plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan Administrator **within 30 days** when the qualifying event is:

- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- With respect to a retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The plan requires you to notify the Plan Administrator **within 60 days** after the qualifying event occurs. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for up to 36 months when the qualifying event is:

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B or both);
- Your divorce or legal separation; or
- A dependent child losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage lasts for **up to 18 months**. There are two ways in which this 18-month period of COBRA continuation can be extended:

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during **the first 60 days** of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive **up to an additional 11 months** of COBRA continuation coverage, **for a total maximum of 29 months**. You must make sure that your Plan Administrator is notified of the Social Security Administration's determination **within 60 days** of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, **up to a maximum of 36 months**. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the plan as a dependent child.

In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, contact the Plan Administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at [www.dol.gov/ebsa].

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan Administrator.

PLAN CONTACT INFORMATION

[Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.]

[Information about the plan and COBRA continuation coverage can be obtained on request by contacting:

[]]

CLAIM PAYMENTS AND APPEALS

FILING CLAIMS

You must submit claims **within 12 months** after the date services or supplies were received. **A claim submitted more than 12 months after the service was received will not be accepted under any circumstance.** If a claim is returned for further information, resubmit it **within 45 days.**

IMPORTANT NOTE ABOUT FILING CLAIMS

This section addresses the procedures for filing claims and appeals. The instructions in no way imply that filing a claim or an appeal will result in benefit payment and do not exempt you from adhering to all of the provisions described in this Benefit Booklet. All claims submitted will be processed by BCBSNM according to the patient's eligibility and benefits in effect at the time services are received. Whether inside or outside New Mexico and/or the United States, you must meet all Admission review and Prior Approval requirements or benefits may be reduced or denied as explained in *Admission Review and Other Prior Approvals.* Covered Services are the same services listed as covered in *Covered Services* and all services are subject to the limitations and exclusions listed throughout this Benefit Booklet.

IF YOU HAVE OTHER VALID COVERAGE

When you have Other Valid Coverage that is primary over this benefit program, you need to file your claim with the other carrier first. (See *Coordination of Benefits and Right of Recovery.*) After your other carrier (including health care insurance, dental or vision plan, Medicare, automobile or other liability insurance, Workers' Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to BCBSNM or to the local BCBS Plan, as instructed under "Where to Send Claim Forms" later in this section.

If the Other Valid Coverage pays benefits to you (or your family member) directly, give your Provider a copy of the payment explanation so that he/she can include it with the claim sent to BCBSNM or to the local BCBS Plan. (If a Nonparticipating Provider does not file claims for you, attach a copy of the payment explanation to the claim that you send to BCBSNM or to the local BCBS Plan, as applicable.)

PARTICIPATING AND PREFERRED PROVIDERS

Your Preferred Provider may have 2 agreements with the local BCBS Plan — a Preferred Provider contract and another Participating Provider contract. Some Providers have only the Participating Provider contract and are not considered Preferred Providers[and their services are **not** covered except during an Emergency or unless listed as an "exception" in the "How Your Plan Works" section]. However, all Participating and Preferred Providers file claims with their local BCBS Plan and payment is made directly to them. Be sure that these Providers know you have health care coverage administered by BCBSNM. Do **not** file claims for these services yourself.

Preferred Providers (and Participating Providers) contracting directly with BCBSNM also have specific timely filing limits in their contracts with BCBSNM. The Providers know that they may not bill the employer or any Member for a service if the Provider does not meet the filing limit for a service (usually 90 days) and the claim for that service is denied due to timely filing limitations.

NONPARTICIPATING PROVIDERS

A Nonparticipating Provider is one that has neither a Preferred or a Participating Provider agreement. If your Nonparticipating Provider does not file a claim for you, submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your Other Valid Coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM Web site at [**www.bcbsnm.com**] or requested from a Customer Service representative.) Complete the claim form using the instructions on the form. (See special claim filing instructions for out-of-country claims under "Where to Send Claim Forms" later in this section.)

ITEMIZED BILLS

Claims for Covered Services must be itemized on the Provider's billing forms or letterhead stationery and must show:

- Member's identification number
- Member's and Subscriber's name and address

- Member's date of birth and relationship to the Subscriber
- name, address and tax ID or social security number of the Provider
- date of service or purchase, diagnosis, type of service or treatment, procedure and amount charged for each service (each service must be listed separately)
- accident or Surgery date (when applicable)

Correctly itemized bills are necessary for your claim to be processed. The only acceptable bills are those from health care Providers. Do not file bills you prepared yourself, canceled checks, balance due statements or cash register receipts. Make a copy of all itemized bills for your records before you send them. The bills are not returned to you. All information on the claim and itemized bills must be readable. If information is missing or is not readable, BCBSNM will return it to you or to the Provider.

Do not file for the same service twice unless asked to do so by a Customer Service representative. If your itemized bills include services previously filed, identify clearly the new charges that you are submitting. All itemized bills for services received outside the United States must be translated into English before being filed with BCBSNM. (See "Where to Send Claim Forms" below, for special instructions regarding out-of-country claims.)

WHERE TO SEND CLAIM FORMS

If your Provider does not file a claim for you, you (not the Provider) are responsible for filing the claim. *Member Claim Forms* are available from a BCBSNM Customer Service representative. **Remember:** Participating and Preferred Providers will file claims for you; these procedures are used only when you must file your own claim. See "Participating and Preferred Providers," earlier in this section for more information.

Medical/Surgical [and Behavioral Health]Claims

When Covered Services are received from Nonparticipating Providers [in an Emergency]in New Mexico, mail the forms and itemized bills to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, New Mexico 87125–7630

[Mental Health[/Chemical Dependency] Claims

Claims for covered Mental Health and Chemical Dependency services received in New Mexico should be submitted to:

Mesa Mental Health
P.O. Box 92165
Albuquerque, NM 87199–2165]

[Drug Plan Claims

If you purchase a prescription or other item covered under the drug plan from a nonparticipating pharmacy or other Provider in an Emergency or if you do not have your ID card with you when purchasing a prescription or other item, you must pay for the prescription in full and then submit a claim to BCBSNM's pharmacy benefit manager. **(Do not send these claims to BCBSNM.)** The bills or receipts must be issued by the pharmacy and must include the pharmacy name and address, drug name, prescription number and amount charged. If not included in your enrollment materials, you can obtain the name and address of the administrator and the necessary claim forms from a Customer Service representative or on the BCBSNM Web site at [**www.bcbsnm.com**.]]

Claims Outside of New Mexico

Claims for Covered Services received outside New Mexico from a Provider that does not contract directly with BCBSNM[(or Mesa Mental Health)] should be sent to the BCBS Plan in the state where services were received. If a Provider will not file a claim for you, ask for an itemized bill and complete it the same way that you would for services received from any other Nonparticipating Provider.

Canada and Puerto Rico Claims

Claims for Covered Services received in Canada or Puerto Rico should be handled the same way as is described under "Outside New Mexico."

Claims Outside of the United States

For covered Inpatient [Emergency]Hospital Services received outside the United States (including Puerto Rico) and Canada, show your BCBSNM ID card. BCBSNM participates in a claim payment program with the Blue Cross and Blue Shield Association. If the Hospital has an agreement with the Association, the Hospital files the claim for you to the appropriate Blue Cross Plan. Payment is made to the Hospital by that Plan and then BCBSNM reimburses the other Plan.

When outside the United States, bills for the following services must be submitted to BCBSNM as described under "Nonparticipating Providers" earlier in this section: 1) Covered Services received [during an Emergency]from Hospitals that do *not* contract with the Association, 2) *all* covered Outpatient Hospital Services and 3) *all* covered [Emergency]Physician services. Make copies of your itemized bills and translate them into English. Submit the original itemized bills, along with the translation, to BCBSNM for benefit determination.

CLAIM PAYMENT PROVISIONS

Most claims will be evaluated and you and/or the Provider notified of the BCBSNM benefit decision **within 30 days** of receiving the claim. If all information needed to process the claim has been submitted, but BCBSNM cannot make a determination **within 30 days**, you will be notified (before the expiration of the 30-day period) that an **additional 15 days** is needed for claim determination.

After a claim has been processed, the Subscriber will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not. **Note:** If a Qualified Child Medical Support Order (QCMSO) is in effect, the QCMSO provisions will be followed. For example, when the Member is a Dependent child of divorced parents, the custodial parent may receive the payment and the EOB.

If a Claim is Denied

If benefits are denied or only partially paid, BCBSNM will notify you of the determination. The notice to you will include: 1) the reasons for denial; 2) a reference to the benefit program provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see "Reconsideration of a Claim"). **Note:** If you disagree with the denial of a Prior Approval request, see "If Your Prior Approval Request is Denied" in *Admission Review and Other Prior Approvals.*

Participating and Preferred Providers

Payments for Covered Services usually are sent directly to network (Preferred or Participating) Providers. The EOB you receive explains the payment.

Nonparticipating Providers

If Covered Services are received from a Nonparticipating Provider in New Mexico[during an Emergency], payments are usually made to the Subscriber (or to the applicable alternate payee when a QCMSO is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the Provider and for paying any amounts greater than Covered Charges plus Copayments, Deductibles, Coinsurance, any penalty amounts and noncovered expenses.

Accident-Related Hospital Services

If services are administered as a result of an accident, a Hospital or treatment Facility may place a lien upon a compromise, settlement or judgement obtained by you when the Facility has not been paid its total billed charges from all other sources.

Overpayments

If BCBSNM makes an erroneous benefit payment for any reason (e.g., Provider billing error, claims processing error), BCBSNM may recover overpayments from you. If you do not refund the overpayment, BCBSNM reserves

the right to withhold future benefits to apply to the amount that you owe BCBSNM and to take legal action to correct payments made in error.

MEDICAID

Payment of benefits for Members eligible for Medicaid is made to the appropriate state agency or to the Provider when required by law.

EARLY DEVELOPMENT DELAY AND DISABILITY

For covered Dependent children **under age 4** who are also eligible for services under the Department of Health's (DOH) "Family, Infant and Toddler" (FIT) program as defined in 7.30.8, NMAC, your BCBSNM benefit program will reimburse the DOH for certain Medically Necessary early intervention services that are provided as part of an individualized family service plan under the FIT program by personnel who are licensed and certified for the DOH's FIT program. The maximum reimbursement under the BCBSNM benefit program is **limited to $3,500** per calendar year. However, amounts paid to DOH for such services are not included in any annual or lifetime benefit maximums under the benefit program. Claims for services payable to the DOH under this provision will be honored only if submitted to BCBSNM by the DOH.

ASSIGNMENT OF BENEFITS

BCBSNM specifically reserves the right to pay the Subscriber directly and to refuse to honor an assignment of benefits in any circumstances. No person may execute any power of attorney to interfere with BCBSNM's right to pay the Subscriber instead of anyone else.

COVERED CHARGE

Provider payments are based upon Preferred Provider and Participating Provider agreements and Covered Charges as determined by BCBSNM. For services received outside of New Mexico, Covered Charges may be based on the local Plan practice (e.g., for out-of-state Providers that contract with their local Blue Cross Blue Shield Plan, the Covered Charge may be based upon the amount negotiated by the other Plan with its own contracted Providers). You are responsible for paying Copayments, Deductibles, Coinsurance, any penalty amounts and noncovered expenses. For Covered Services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

BLUECARD PROGRAM

Other Blue Cross and Blue Shield Plans outside of New Mexico (Host Blue) may have contracts with certain Providers in their service areas. Under BlueCard, when you receive Covered Services outside of New Mexico from a Host Blue contracting Provider that does not have a contract with BCBSNM, the amount you pay for Covered Services is calculated on the lower of:

- the billed charges for your Covered Services or
- the negotiated price that the Host Blue passes on to BCBSNM.

Here's an example of how this calculation could work. Suppose you receive Covered Services for an illness while you are on vacation outside of New Mexico. You show your identification card to the Provider to let him or her know that you are covered by BCBSNM. The Provider has negotiated with the Host Blue a price of $80, even though the Provider's standard charge for this service is $100. In this example, the Provider bills the Host Blue $100. The Host Blue, in turn, forwards the claim to BCBSNM and indicates that the negotiated price for the Covered Service is $80. BCBSNM would then base the amount you must pay for the service — the amount applied to your Deductible, if any, and your Coinsurance — on the $80 negotiated price, not the $100 billed charge. So, for example, if your Coinsurance is 20 percent, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a Covered Service.

Please Note: The Coinsurance in the above example is for illustration purposes only. The example assumes that you have met your Deductible and that there are no Copayments associated with the service rendered. Look at the *Benefit Highlights* for your payment responsibilities under this benefit program.

Often, this "negotiated price" is a **simple discount** that reflects the actual price the Host Blue pays. Sometimes, it is an **estimated price** that takes into account special arrangements the Host Blue has with an individual Provider or a group of Providers. Such arrangements may include settlements, withholds, non-claims transactions and/or other types of

variable payments. The "negotiated price" may also be an **average price** based on a discount that results in expected average savings (after taking into account the same special arrangements used to obtain an estimated price). Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted from time to time to correct for over– or underestimation of past prices. However, the amount used by BCBSNM to calculate your share of the billed amount is considered a final price. Laws in a small number of states may require the Host Blue to 1) use another method for or 2) add a surcharge to, your liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would calculate your liability for any Covered Services according to the applicable state law in effect when you received care.

[RECONSIDERATION OF A CLAIM

BCBSNM has established written procedures for reviewing and resolving your concerns. There are two different procedures depending on the type of issue involved. This is a summary of the procedures that apply to claims for services that you have already received ("post-service claims") and other non-utilization management issues. ("Non-utilization management" involves subjects that are not related to the denial of a Prior Approval request, such as inquiries or concerns about any BCBSNM claims payment, claims that have been denied or only partially paid, the quality of care you receive or the cancellation of your coverage.) If a Prior Approval request is denied, terminated or reduced, please refer to "If Your Prior Approval Request is Denied" in *Admission Review and Other Prior Approvals*. You may request a detailed written explanation of the complaint, reconsideration and appeal procedures by calling BCBSNM Customer Service.

You may designate a representative to act for you in the review and reconsideration procedures. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative.

If you make an inquiry or request a reconsideration under the following procedures, you will not be subject to retaliatory action by BCBSNM.

Initial Informal Review of Claim Decision/Complaint

If you have an inquiry or a concern about any non-utilization management review decisions, call a Customer Service representative for assistance. Many complaints or problems can be handled informally by calling or writing BCBSNM Customer Service. If you make an oral complaint, a BCBSNM Customer Service representative will assist you.

If your request for claim payment has been denied in whole or in part, you may ask BCBSNM to review its benefit determination. **Within 180 days** after you receive notice of an adverse determination (denial or partial denial) on a claim, call or write to BCBSNM Customer Service and explain your reasons for disagreeing with the determination. You may also ask to see relevant documents and may submit written issues, comments and additional medical information. Requests for review received **more than 180 days** following notification will not be considered unless you can satisfy BCBSNM that matters beyond your control prevented an earlier request for review.

Reconsideration of Claim Decision/Complaint

If you are dissatisfied with the results of the informal review, you may file a request for reconsideration. Call a BCBSNM Customer Service representative for assistance. Send your request to a BCBSNM Customer Service representative and, if possible, include:

- a copy of the Explanation of Benefits (EOB) and/or denial letter; and
- copies of related medical records from your Provider; and
- any additional information from your Provider in support of your request.

The formal reconsideration request must be filed to BCBSNM within **180 days** of the date the first denial or payment notice is mailed. If you do not file the reconsideration request within the 180-day period, you waive your right to request a reconsideration or to appeal.

BCBSNM will acknowledge receipt of the request for reconsideration. BCBSNM will review your request and give you a decision **within 60 calendar days,** unless you are asked for more information. If there is no change in the original decision, you are provided reasons in writing.

If you are still not satisfied after having completed the BCBSNM reconsideration procedure (for claims for services already received and described above), you have the option of taking additional steps as outlined below. (You may not take legal action to recover benefits under [or make an arbitration demand] against this plan **until 60 days after** we have received the claim in question. Also, you may not take any legal action [or make an arbitration demand] **after 3 years** from the date that the claim in question must be filed with BCBSNM. See below as to right to file a legal action if you are in an ERISA plan[and right to demand arbitration if you are in a non-ERISA plan.])

[RECONSIDERATION OF A CLAIM

Many complaints or problems can be handled informally by calling or writing BCBSNM Customer Service. If you make an oral complaint, a BCBSNM Customer Service representative will assist you.

If your request for claim payment or prior approval has been denied in whole or in part, you may ask BCBSNM to review its benefit determination. **Within 180 days** after you receive notice of an adverse determination (denial or partial denial) on a claim, call or write to BCBSNM Customer Service and explain your reasons for disagreeing with the determination. You may also ask to see relevant documents and may submit written issues, comments and additional medical information. Requests for review received **more than 180 days** following notification will not be considered unless you can satisfy BCBSNM that matters beyond your control prevented an earlier request for review.

If you are dissatisfied with the results of the informal review, you may file a request for reconsideration. Call a BCBSNM Customer Service representative for assistance. Send your request to a BCBSNM Customer Service representative and, if possible, include:

- a copy of the Explanation of Benefits (EOB) and/or denial letter; and
- copies of related medical records from your Provider; and
- any additional information from your Provider in support of your request.

The formal reconsideration request must be filed to BCBSNM **within 180 days** of the date the first denial or payment notice is mailed. If you do not file the reconsideration request within the 180-day period, you waive your right to request a reconsideration or to appeal.

BCBSNM will acknowledge receipt of the request for reconsideration. BCBSNM will review your request and give you a decision **within 60 calendar days**, unless you are asked for more information. If there is no change in the original decision, you are provided reasons in writing.

If you are still not satisfied after having completed the BCBSNM reconsideration procedure (for claims for services already received and described above, you have the option of taking one or more of the following steps. (No arbitration demand made under a non-ERISA plan, **less than 60 days** after BCBSNM has received the claim for benefits or Prior Approval request or later than three years after the date that the claim for benefits should have been filed with BCBSNM.)]

[EXTERNAL APPEAL FOR ERISA PLANS

This benefit program provided by your Group may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The “External Appeal for ERISA Plans” right is applicable to all Group plans except Governmental Plans, Church Plans and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens. Therefore, if this benefit program is governed by ERISA and you are still not satisfied after having completed the reconsideration or appeal process administered by BCBSNM, you may have a right to bring a civil action under ERISA section 502(a).]

[ARBITRATION FOR NON-ERISA PLANS

The “Arbitration for non-ERISA Plans” provision applies to all Governmental Plans, Church Plans and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens. If a dispute about coverage, benefits or handling of claims or Prior Approval requests continues after the Member has followed and exhausted the reconsideration or appeal process administered by BCBSNM, the issue or claim shall be submitted to arbitration upon agreement by the Member. The rules for arbitration shall be the “Commercial Arbitration Rules” developed by the American Arbitration Association. You may obtain a copy of these rules from a Customer Service representative. The rules are also available from the American Arbitration Association’s Web site ([www.adr.org]). The use of arbitration does not limit your ability to seek other means by which to resolve disputes, but is an avenue available to you.]

GENERAL PROVISIONS

APPLICATION STATEMENT

No statement (except a fraudulent statement) you make in any application for coverage that is **more than 2 years old** can void this coverage or be used against you in any legal action or proceeding relating to this coverage unless the application or a true copy of it is incorporated in or attached to the contract.

AVAILABILITY OF PROVIDER SERVICES

BCBSNM does not guarantee that a certain type of room or service will be available at any Hospital or other Facility within the BCBSNM network, nor that the services of a particular Hospital, Physician or other Provider will be available.

CATASTROPHIC EVENTS

In case of fire, flood, war, civil disturbance, court order, strike or other cause beyond BCBSNM's control, BCBSNM may be unable to process claims or provide Prior Approval for services on a timely basis. If due to circumstances not within the control of BCBSNM or a network Provider (such as partial or complete destruction of facilities, war, riot, disability of a network Provider or similar case), BCBSNM and the Provider will have no liability or obligation if medical services are delayed or not provided. BCBSNM and its network Providers will, however, make a good-faith effort to provide services.

CHANGES TO THE BENEFIT BOOKLET

BCBSNM may amend this Benefit Booklet when authorized by an officer of BCBSNM. BCBSNM will give your Group **at least 30 days'** prior written notice of an amendment to this Benefit Booklet. No employee of BCBSNM may change this Benefit Booklet by giving incomplete or incorrect information or by contradicting the terms of this Benefit Booklet. Any such situation will not prevent BCBSNM from administering this Benefit Booklet in strict accordance with its terms.

DISCLAIMER OF LIABILITY

BCBSNM has no control over any diagnosis, treatment, care or other service provided to you by any Facility or professional Provider, whether preferred or not. BCBSNM is not liable for any loss or injury caused by any health care Provider by reason of negligence or otherwise.

DISCLOSURE AND RELEASE OF INFORMATION

BCBSNM will only disclose information as permitted or required under state and federal law.

ENTIRE CONTRACT

This Benefit Booklet (and any amendments, riders[, *Benefit Highlights* inserts]and endorsements), your Group enrollment/change application and your Identification Card shall constitute the entire contract. All statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written application for coverage.

EXECUTION OF PAPERS

On behalf of yourself and your Dependents you must, upon request, execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this benefit program.

INDEPENDENT CONTRACTORS

The relationship between BCBSNM and its network Providers is that of independent contractors; Physicians and other Providers are not agents or employees of BCBSNM and BCBSNM and its employees are not employees or agents of any network Provider. BCBSNM will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any network Provider. The relationship between BCBSNM and the Group is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of the employer.

MEMBER RIGHTS AND RESPONSIBILITIES

You have a right to receive information about BCBSNM, its services, its network practitioners and Providers and Members' rights and responsibilities;

- a right to receive information about BCBSNM, its services, its network practitioners and Providers and Member's rights and responsibility;
- a right to be treated with respect and recognition of your dignity and right to privacy;
- a right to a candid discussion with your treating Provider of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage;
- a right to voice complaints or appeals about BCBSNM or the health care coverage it provides;
- a right to make recommendations regarding BCBSNM's Member rights and responsibilities policies;
- a responsibility to supply information (to the extent possible) that BCBSNM and its network practitioners and Providers need in order to provide care;
- a responsibility to follow plans and instructions for care that you have agreed on with your treating Provider or practitioners; and
- a responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals with your treating Provider or practitioner to the degree possible.

MEMBERSHIP RECORDS

BCBSNM will keep membership records and the employer will periodically forward information to BCBSNM to administer the benefits of this benefit program. You can inspect all records concerning your membership in this benefit program during normal business hours given reasonable advance notice.

RESEARCH FEES

BCBSNM reserves the right to charge you an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters or other forms.

SENDING NOTICES

All notices to you are considered to be sent to and received by you when deposited in the United States mail with first-class postage prepaid and addressed to the Subscriber at the latest address on BCBSNM membership records or to the employer.

DEFINITIONS

It is important for you to understand the meaning of the following terms. The definition of many terms determines your benefit eligibility.

Accidental Injury — A bodily injury caused solely by external, traumatic and unforeseen means. Accidental Injury does not include disease or infection, hernia or cerebral vascular accident. Dental injury caused by chewing, biting or malocclusion is not considered an Accidental Injury.

Acupuncture — The use of needles inserted into the human body for the prevention, cure or correction of any disease, illness, injury, pain or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore health.[This benefit program does not cover acupuncture.]

Admission — The period of time between the dates a patient enters a Facility as an Inpatient and is discharged as an Inpatient. (If you are an Inpatient at the time your coverage either begins or ends, benefits for the Admission will be available only for those Covered Services received on and after your Effective Date of Coverage or those received before your termination date.)

Alcoholism — Conditions defined by patterns of usage that continue despite occupational, marital or physical problems that are related to aberrant use of alcohol. Alcoholism may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol is discontinued.

Alcoholism Treatment Facility, Alcoholism Treatment Program — An appropriately licensed Provider of Medical Detoxification and rehabilitation treatment for Alcoholism.

Ambulance — A specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an Ambulance.

Ambulatory Surgical Facility — An appropriately licensed Provider, with an organized staff of Physicians, that meets all of the following criteria:

- has permanent Facilities and equipment for the primary purpose of performing Surgical Procedures on an Outpatient basis; *and*
- provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the Facility; *and*
- does not provide Inpatient accommodations; *and*
- is not a Facility used primarily as an office or clinic for the private practice of a Physician or other Provider.

Appliance — A device used to provide a functional or therapeutic effect.

Benefit Booklet — This document or evidence of coverage, which explains the benefits, limitations, exclusions, terms and conditions of your benefit program.

[**Benefit Period** — A period of one year that begins on January 1 and ends on December 31 of the same year. The Initial Benefit Period is from a Member's Effective Date of Coverage and ends on December 31, which may be less than 12 months.]

[**Benefit Period** — A period of one year that begins on [Month Day] and ends on [Month Day] of the following year. The Initial Benefit Period is from a Member's Effective Date of Coverage but ends on the date it would normally end, which may be less than 12 months.]

Blue Cross and Blue Shield of New Mexico — A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association; also referred to as BCBSNM.

[**Brand-Name Drug** — A drug that is available from only one source or when available from multiple sources is protected with a patent.]

Cancer Clinical Trial — A course of treatment provided to a patient for the prevention of reoccurrence, early detection or treatment or palliation of cancer for which standard cancer treatment has not been effective or does not exist. It does not include trials designed to test toxicity or disease pathophysiology, but must have a therapeutic intent and be provided as part of a study being conducted in a phase II, III or IV Cancer Clinical Trial. The scientific study must have been approved by an institutional review board that has an active federal-wide assurance of protection for human subjects and include all of the following: specific goals, a rationale and background for the study, criteria for patient selection, specific direction for administering the therapy or intervention and for monitoring patients, a definition of quantitative measures for determining treatment response, methods for documenting and treating adverse reactions and a reasonable expectation, based on clinical or pre-clinical data, that the treatment will be at least as efficacious as standard cancer treatment. The trial must have been approved by a United States federal agency or by a qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.

Cardiac Rehabilitation — An individualized, supervised physical reconditioning exercise session lasting from 4-12 weeks. Also includes education on nutrition and heart disease.

Certified Nurse-Midwife — A person who is licensed by the Board of Nursing as a Registered Nurse and who is licensed by the New Mexico Department of Health (or appropriate state regulatory body) as a Certified Nurse-Midwife.

Certified Nurse Practitioner — A Registered Nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the Board of Nursing.

Cessation Counseling — As applied to the "Smoking/Tobacco Use Cessation" benefit described in *Covered Services*, Cessation Counseling means a program, including individual, group or proactive telephone quit line, that:

- is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow-up;
- operates under a written program outline that meets minimum requirements established by the NM Public Regulation Commission;
- employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

Chemical Dependency — Conditions defined by patterns of usage that continue despite occupational, marital or physical problems that are related to aberrant use of alcohol, drugs or other substance. Chemical Dependency (also referred to as "substance abuse," which includes Alcoholism or Drug Abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol, drugs or other substance is discontinued.

Chemotherapy — Drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Child — See definition of "Dependent".

Chiropractor — A person who is a doctor of chiropractic (D.C.) licensed by the appropriate governmental agency to practice chiropractic medicine.

[**Church Plan** — That term as defined pursuant to Section 3(33) of the Federal Employee Retirement Income Security Act of 1974.]

Clinical Psychologist — A person with a doctoral degree in clinical psychology licensed or certified in accordance with the New Mexico Professional Psychologist Act or similar statute in another state.

Coinsurance — A percentage of Covered Charges that you are required to pay towards a Covered Service. For Covered Services that are subject to Coinsurance, you pay the percentage (indicated in the *Benefit Highlights*) of BCBSNM's Covered Charge after the Deductible (if any) has been met. Also see "Claim Payment Provisions" in *Claim Payments and Appeals*.

Copayment — A fixed-dollar amount that you are required to pay towards some Covered Services.

Cosmetic — See the "Cosmetic Services" exclusion in *General Limitations and Exclusions.*

Cost-Effective — A procedure, service or supply that is an economically efficient use of resources with respect to cost, relative to the benefits and harms associated with the procedure, service or supply. When determining Cost-Effectiveness, the situation and characteristics of the individual patient are considered.

Covered Charge — The amount BCBSNM determines is a fair and reasonable allowance for a particular Covered Service. After your share of a Covered Charge (e.g., Deductible, Coinsurance[, Copayment] and/or penalty amount) has been calculated, BCBSNM pays the remaining amount of the Covered Charge, up to maximum benefit limits, if any. **The Covered Charge may be less than the billed charge.**[Your choice of Provider will determine if you will also have to pay the difference between the Covered Charge and the billed charge.] Also see "Claim Payment Provision" in *Claim Payments and Appeals*.

Covered Services — Those services and other items for which benefits are available under the terms of the benefit program of an eligible plan Member.

Creditable Coverage — Health care coverage through an employment-based Group Health Care Plan; health insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely of benefits pursuant to section 1928 of that title; 10 USCA Chapter 55 (military benefits); a medical care program of the Indian Health Service or of an Indian nation, tribe or pueblo; the NM Medical Insurance Pool (NMMIP) Act or similar state sponsored health insurance pool; a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether foreign or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children's Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act.

Deductible — The amount of Covered Charges that you must pay in a Benefit Period before this benefit program begins to pay its share of [Nonpreferred Provider]Covered Charges you incur during the same Benefit Period. If the Deductible amount remains the same during the Benefit Period, you pay it only once each Benefit Period and it applies to all [Nonpreferred Provider]Covered Services you receive during that Benefit Period.[(There is no annual Deductible to meet for services of a Preferred Provider.)]

Dental-Related Services — Services performed for treatment or conditions related to the teeth or structures supporting the teeth.

Dentist, Oral Surgeon — A doctor of dental Surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) who is licensed to practice prevention, diagnosis and treatment of diseases, Accidental Injuries and malformation of the teeth, jaws and mouth.

Dependents — Family members of the Subscriber, limited to the following persons:

- the Subscriber's legal **spouse**
- the Subscriber's unmarried **child** through the end of the month in which the child becomes age **25** (At that time, the child is automatically removed from coverage as a Dependent.)
- the Subscriber's unmarried child age 25 or older who was enrolled as a Dependent at the time of reaching the age limit and who is medically certified as **handicapped** and chiefly dependent upon the Subscriber for support and maintenance (Such condition must be certified by a Physician and BCBSNM. Also, a child may continue to be eligible for coverage beyond the Dependent age limit only if the condition began before or dur-

ing the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition before the end of the month during which the child's coverage would otherwise end.)

Child — A child is considered to be a specific age on the first day of the month following his/her birthday and includes an unmarried:

- natural or legally adopted child of the Subscriber whether or not the Subscriber is the parent and whether or not the child is claimed on income tax or residing in the Subscriber's home
- child under age 18 placed in the Subscriber's home for purposes of adoption
- stepchild of the Subscriber
- child for whom the Subscriber is the legal guardian
- child for whom the Subscriber must provide coverage because of a court or administrative order pursuant to state law

BCBSNM may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers or court orders) that an individual qualifies as a Dependent under this coverage. Unless listed as a Dependent, no other family member, relative or person is eligible for coverage as a Dependent.

Diagnostic Services — Procedures such as laboratory and pathology tests, x-ray services, EKGs and EEGs that do not require the use of an operating or recovery room and that are ordered by a Provider to determine a condition or disease.

Dialysis — The treatment of a kidney ailment during which impurities are mechanically removed from the body with Dialysis equipment.

Doctor of Oriental Medicine — A person who is a Doctor of Oriental Medicine (D.O.M.) licensed by the appropriate governmental agency to practice Acupuncture and oriental medicine.

Drug Abuse — A condition defined by patterns of usage that continue despite occupational, marital or physical problems related to aberrant use of drugs or other non-alcoholic substance. There may also be significant risk of severe withdrawal symptoms if the use of drugs is discontinued. Drug Abuse does not include nicotine addiction or Alcoholism.

Drug Abuse Treatment Facility — An appropriately licensed Provider primarily engaged in Medical Detoxification and rehabilitation treatment for Chemical Dependency.

[**Drug List** — A list of Prescription Drugs that are preferred for use by BCBSNM for retail and mail-order pharmacy benefits. You pay the lower "Tier-One" and "Tier-Two" Copayments for drugs listed in the BCBSNM Drug List. You pay the higher "Tier–Three" Copayment for drugs not listed. The list is subject to periodic review and change by BCBSNM. BCBSNM-contracted Providers should have received a copy of the list. If you need a list of commonly prescribed drugs on the BCBSNM Drug List, request it from a Customer Service representative or visit the BCBSNM Web site. Your drug plan may or may not use a Drug List. See[your separately issued *Drug Plan Rider* for details.][See *Prescription Drugs and Other Items* for details.]]

[**Drug Plan Rider** — The document that explains the coverage available to you for Prescription Drugs, insulin, diabetic supplies and certain nutritional products.]

Durable Medical Equipment — Any equipment that can withstand repeated use, is made to serve a medical purpose and is generally considered useless to a person who is not ill or injured.

Effective Date of Coverage — 12:01 a.m. of the date on which a Member's coverage begins.

Emergency, Emergency Care — Medical or Surgical Procedures, treatments or services delivered immediately after an Accidental Injury or the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious

dysfunction of any bodily organ or part or disfigurement. Initial treatment must be sought **within 48 hours** of the accident or onset of symptoms to qualify as an Emergency. If you are hospitalized **within 48 hours** of an Emergency occurrence, the entire related Inpatient hospitalization is considered part of the initial treatment.

Employee Probationary Period — The number of months or days of continuous employment beginning with the employee's most recent date of hire and ending on the date the employee first becomes eligible for coverage under the employer's Group. Your employer determines the length of the probationary period.

Enteral Nutritional Products — A product designed to provide calories, protein, and essential micronutrients by the enteral route (i.e., by the gastrointestinal tract, which includes the stomach and small intestine only).

Experimental, Investigational or Unproven — See the "Experimental, Investigational or Unproven Services" exclusion in *General Limitations and Exclusions*.

Facility — A Hospital or other institution (also, see "Provider" later in this section).

[**Generic Drug** — The chemical equivalent of a Brand-Name Drug. According to the U.S. Food and Drug Administration (FDA) regulations, Brand-Name Drugs and Generic Drugs must meet the same standards for safety, purity, strength, and quality. A Generic Drug is usually available from multiple sources and is not protected by a patent.]

Genetic Inborn Error of Metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death and requires that the affected person consume Special Medical Foods.

Good Cause — Failure of the Subscriber to pay the premiums or other applicable charges for coverage; a material failure to abide by the rules, policies or procedures of this benefit program; or fraud or material misrepresentation affecting coverage.

[**Governmental Plan** — That term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal Governmental Plan (a Governmental Plan established or maintained for its employees by the United States government or an instrumentality of that government).]

Group — A bonafide employer covering employees of such employer for the benefit of persons other than the employer; or an association, including a labor union, that has a constitution and bylaws and is organized and maintained in good faith for purposes other than that of obtaining insurance.

[**Group Health Care Plan** — An employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care (directly or through insurance, reimbursement or otherwise) to employees or their Dependents (as defined under the terms of the benefit program).]

Group Master Application — The application for coverage completed by the employer (or association representative).

Group Master Contract — A contract for health care services which by its terms limits eligibility to members of a specified Group. The Group Master Contract includes the Group Master Application and may include coverage for Dependents.

Home Health Care Agency — An appropriately licensed Provider that both:

- brings Skilled Nursing Care and other services on an intermittent, visiting basis into your home in accordance with the licensing regulations for Home Health Care Agencies in New Mexico or in the state where the services are provided; *and*
- is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the attending Physician.

Home Health Care Services — Covered Services, as listed under "Home Health Care/Home I.V. Services" in *Covered Services,* that are provided in the home according to a treatment plan by a certified Home Health Care Agency

under active Physician and nursing management. Registered Nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician.

Hospice — A licensed program providing care and support to Terminally Ill Patients and their families. An approved Hospice must be licensed when required, Medicare-certified as, or accredited by, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as, a Hospice.

Hospice Benefit Period — The period of time during which Hospice benefits are available. It begins on the date the attending Physician certifies that the Member is a Terminally Ill Patient and ends **6 months** after the period began (or upon the Member's death, if sooner). The Hospice Benefit Period must begin while the Member is covered for these benefits and coverage must be maintained throughout the Hospice Benefit Period.

Hospice Care — An alternative way of caring for Terminally Ill Patients in the home or institutional setting, which stresses controlling pain and relieving symptoms but does not cure. Supportive services are offered to the family before the death of the patient.

Hospital — A health institution offering facilities, beds and continuous services 24 hours a day, 7 days a week. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies. Services provided include:

- diagnosis and treatment of illness, injury, deformity, abnormality or pregnancy
- clinical laboratory, diagnostic x-ray and definitive medical treatment provided by an organized medical staff within the institution
- treatment Facilities for Emergency Care and Surgical Services either within the institution or through a contractual arrangement with another licensed Hospital (These contracted services must be documented by a well-defined plan and related to community needs.)

  A Hospital is not, other than incidentally, a Skilled Nursing Facility, nursing home, custodial care home, health resort, spa or sanatorium; is not a place for rest, the aging or the treatment of Mental Health Disorders, Alcoholism, Drug Abuse or pulmonary tuberculosis; ordinarily does not provide Hospice or rehabilitation care; and is not a Residential Treatment Facility.

Identification Card (ID Card) — The card BCBSNM issues to the Subscriber that identifies the cardholder as a benefit program Member.

Initial Enrollment Eligibility Date — A Member's Effective Date of Coverage or the first day of any Employee Probationary Period imposed on the Member by the employer, whichever is earlier. For a Late Applicant or for a person applying under a special enrollment provision, the Initial Enrollment Eligibility Date is his/her Effective Date of Coverage.

Inpatient, Inpatient Services — Care provided while you are confined as an Inpatient in a Hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 3-12 hours of continuous psychiatric care in a treatment Facility). Inpatient Hospital services include, but are not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral nutrition when Medically Necessary, Physician and surgeon services, use of all Hospital facilities when use of such facilities is determined to be Medically Necessary by your treating Physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when Medically Necessary, Radiation Therapy, inhalation therapy and administration of whole blood and blood components when Medically Necessary.

Investigational Drug or Device — For purposes of the "Cancer Clinical Trial" benefit described in *Covered Services* under "Rehabilitation and Other Therapy," a drug or device that has not been approved by the federal Food and Drug Administration.

Involuntary Loss of Coverage — As applied to Special Enrollment provisions, Loss of other coverage due to legal separation, divorce, death, moving out of an HMO service area, termination of employment, reduction in hours or termination of employer contributions (even if the affected Member continues such coverage by paying the amount previously paid by the employer). A loss of coverage may also occur if your employer ceased offering coverage to the particular class of workers or similarly situated individuals to which you belonged or terminated your benefit package

option and no substitute plan was offered. If the Member is covered under a state or federal continuation policy due to prior employment, Involuntary Loss of Coverage includes exhaustion of the maximum continuation time period. Involuntary Loss of Coverage does not include a loss of coverage due to the failure of the individual or Member to pay premiums on a timely basis or termination of coverage for Good Cause.

[**Late Applicant** — Unless eligible for a special enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this benefit program (e.g., a newborn child added to coverage **more than 31 days** after birth when [Family coverage (or Employee/Children, if available)] is not already in effect, a child added **more than 31 days** after legal adoption, a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the Group's initial BCBSNM enrollment date who was not covered under the Group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the Group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)]

Licensed Midwife — A person who practices lay midwifery and is registered as a Licensed Midwife by the New Mexico Department of Health (or appropriate state regulatory body).

Licensed Practical Nurse (L.P.N.) — A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

[**Maintenance Medications** — Prescription Drugs taken regularly to treat a chronic health condition, such as high blood pressure or diabetes.]

[**Maternity** — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), [elective abortion] or C-section. See "Maternity/Reproductive Services and Newborn Care" in *Covered Services* for more information.]

Medicaid — A state-funded program that provides medical care for indigent persons, as established under Title XIV of the Social Security Act of 1965, as amended.

Medical Detoxification — Treatment in an acute care Facility for withdrawal from the physiological effects of Alcoholism or Drug Abuse. (Detoxification usually takes about three days in an acute care Facility.)

Medical Policy — A coverage position developed by BCBSNM that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies or drugs and used by BCBSNM to adjudicate claims and provide benefits for Covered Services. Medical Policies are posted on the BCBSNM Web site for review or copies of specific Medical Policies may be requested in writing from a Customer Service representative.

Medical Supplies — Expendable items (except Prescription Drugs) ordered by a Physician or other professional Provider, that are required for the treatment of an illness or Accidental Injury.

Medically Necessary, Medical Necessity — See "Medically Necessary Services" in *Covered Services.*

Medicare — The program of health care for the aged, end-stage renal disease (ESRD) patients and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

Member — The enrollee (the Subscriber or any eligible Dependent) who is enrolled for coverage and entitled to receive benefits under this benefit program in accordance with the terms of the Group Master Contract. Throughout this Benefit Booklet, the terms "you" and "your" refer to each Member.

Mental Health Disorder — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental Health Disorder does not include developmental disabilities, Chemical Dependency or learning disabilities.

Nonparticipating Provider — An appropriately licensed health care Provider that has not contracted directly or indirectly, for the service being provided, with BCBSNM. [See *Benefit Highlights* for those services that are not covered if received from a Nonpreferred Provider (all Nonparticipating Providers are also Nonpreferred Providers).]

Nonpreferred Provider — Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the Preferred (or PPO) Provider network. (These Providers may have Participating Provider agreements, but are **not** considered Preferred Providers. See "Participating Provider" for more information.) [**Note: See *Benefit Highlights* for those services that are not covered if received from a Nonpreferred Provider.**]

Occupational Therapist — A person registered to practice Occupational Therapy. An Occupational Therapist treats neuromuscular and psychological dysfunction caused by disease, trauma, congenital anomaly or prior therapeutic process through the use of specific tasks or goal-directed activities designed to improve functional performance of the patient.

Occupational Therapy — The use of rehabilitative techniques to improve a patient's functional ability to perform activities of daily living.

Optometrist — A doctor of optometry (O.D.) licensed to examine and test eyes and treat visual defects by prescribing and adapting corrective lenses and other optical aids.

Orthopedic Appliance — An individualized rigid or semirigid support that eliminates, restricts or supports motion of a weak, injured, deformed or diseased body part; for example, functional hand or leg brace, Milwaukee brace or fracture brace.

Other Valid Coverage — All other Group and individual (or direct-pay) insurance policies or health care benefit plans (including Medicare, but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services will be considered Other Valid Coverage for purposes of coordinating benefits under this benefit program.

Other Providers — Clinical Psychologists and the following masters-degreed psychotherapists (an independently **licensed** professional Provider with either an M.A. or M.S. degree in psychology or counseling): licensed independent social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters-level Registered Nurse certified in psychiatric counseling (R.N.C.S.); licensed marriage and family therapist (L.M.F.T.). For Chemical Dependency services, a Provider also includes a licensed alcohol and Drug Abuse counselor (L.A.D.A.C.).

Out-of-Pocket Limit — The maximum amount of Deductible[, Copayment] and Coinsurance that you pay for most Covered Services in a Benefit Period. After an Out-of-Pocket Limit is reached, this benefit program pays **100 percent** of most of your [Preferred or Nonpreferred Provider]Covered Charges for the rest of that Benefit Period, not to exceed any benefit limits.

Outpatient, Outpatient Services — Medical/Surgical Services received in the Outpatient department of a Hospital, observation room, emergency room, Ambulatory Surgical Facility, freestanding Dialysis Facility or other covered Outpatient treatment Facility. Outpatient medical services include those Hospital services that can reasonably be provided on an ambulatory basis and those preventive, Medically Necessary, diagnostic and treatment procedures prescribed by your attending Physician. Such services may be provided at a Hospital, a Physician's office, any other appropriate licensed Facility or at any other appropriate Facility if the professional delivering the services is licensed to practice, is certified and is practicing under authority of the health care insurer, a medical group, an independent practice association or other authority authorized by applicable New Mexico law.

[**Participating Pharmacy** — A retail supplier that has contracted with BCBSNM or its authorized representative to dispense covered Prescription Drugs and medicines, insulin, diabetic supplies, and nutritional products to Members, and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative. [Some Participating Pharmacies are contracted with BCBSNM to provide Specialty Pharmacy Drugs to

Members; these pharmacies are called "Specialty Pharmacy Drug Providers" and some drugs must be dispensed by these specially contracted pharmacy Providers in order to be covered.]]

Participating Provider — Any Provider that, for the service being provided, contracts with BCBSNM, a BCBSNM contractor or subcontractor, another Blue Cross Blue Shield (BCBS) Plan or the national BCBS Transplant network. Your Preferred Provider may have two agreements with the local BCBS Plan — a Preferred Provider contract and another Participating Provider contract. Providers that have only the Participating Provider contract are **not** considered Preferred Providers. See definition of "Provider."

Physical Therapist — A licensed Physical Therapist. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body. A Physical Therapist treats disease or Accidental Injury by physical and mechanical means (regulated exercise, water, light or heat).

Physical Therapy — The use of physical agents to treat disability resulting from disease or injury. Physical agents include heat, cold, electrical currents, ultrasound, ultraviolet radiation and therapeutic exercise.

Physician — See definition of "Provider."

Podiatrist — A licensed doctor of podiatric medicine (D.P.M.). A podiatrist treats conditions of the feet.

[**PPO Primary Provider (PPP)** — See definition of "Provider."]

Practitioner of the Healing Arts — See definition of "Provider."

[**Preexisting Conditions** — A physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant **within a** [3–6 months] **month period** before his/her Initial Enrollment Eligibility Date. Pregnancy, Pregnancy-Related Services and diagnoses are not considered Preexisting Conditions.]

Preferred Provider[**or Preferred Specialist**] — See definition of "Provider."

Pregnancy-Related Services — See definition of "Maternity."

[**Prescription Drugs, Medicines and Devices** — Those that are taken at the discretion and under the supervision of a Provider, that require a prescription before being dispensed, and are labeled as such on their packages. All Prescriptions Drugs, Medicines and Devices must be approved by the FDA, and must not be Experimental, Investigational, or Unproven. (See "Experimental, Investigational, or Unproven Service" in *General Limitations and Exclusions*.)]

Preventive Care Services — Professional services rendered for the early detection of asymptomatic illnesses or abnormalities and to prevent illness or other conditions.

Prior Approval — A requirement that you or your Provider must obtain authorization from BCBSNM before you are admitted as an Inpatient (Admission review approval) and before you receive certain types of services (other Prior Approvals).

Prosthetics or Prosthetic Device — An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider — A duly licensed Hospital, Physician or other Practitioner of the Healing Arts authorized to furnish health care services within the scope of licensure.

Health Care Facility: An institution providing health care services, including a Hospital or other licensed Inpatient center, an Ambulatory Surgical Facility, a Skilled Nursing Facility, a Home Health Care Agency, a diagnostic laboratory or imaging center and a rehabilitation or other therapeutic health setting.

Physician: A Practitioner of the Healing Arts who is also a doctor of medicine (M.D.) or osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Practitioner of the Healing Arts: Any Physician, professional Provider or other person holding a licence or certificate provided for in Chapter 61, Article 4,5,6 or 14A NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, or operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition.

A Provider may belong to one or more networks, but if you want to visit a network Provider, you must choose the Provider from the *appropriate* network:

[**PPO Primary Provider (PPP):** A Preferred Provider in one of the following medical specialties **only:** Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do **not** include Physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery or Pediatric Allergy.]

[**PPO Specialist:** A Practitioner of the Healing Arts who has a Preferred Provider contract with his/her BCBS Plan and who is **not** a PPO Primary Provider.]

[**Preferred (PPO) Provider:** Practitioners of the Healing Arts and Facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as Preferred (or PPO) Providers. These Providers belong to the Preferred Provider Network.]

Transplant Provider: These Providers have contracted with BCBSNM through the Blue Cross and Blue Shield Association to provide Transplant services covered under this benefit program. They belong to the National BCBS Transplant Network.

[**Participating Pharmacy:** Retail suppliers that have contracted with BCBSNM or its authorized representatives to dispense Prescription Drugs and medicines, insulin, diabetic supplies, Special Medical Foods and enteral nutritional products covered under the drug plan portion of the health care plan and that have contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representatives. They belong to the "Retail Pharmacy Network."]

A network Provider agrees to provide health care services to Members with an expectation of receiving payment (other than [Copayments,] Coinsurance or Deductibles) directly or indirectly from BCBSNM (or other entity with whom the Provider has contracted). A network Provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this benefit program's payment (provided in accordance with the provisions of the contract) plus the Member's share (Coinsurance, Deductibles, Copayments, etc.) as payment in full for Covered Services. BCBSNM (or other contracting entity) will pay the network Provider directly. BCBSNM (or other contracting entity) may add, change or terminate specific network Providers at its discretion or recommend a specific Provider for specialized care as Medical Necessity warrants.

Psychiatric Hospital — A psychiatric Facility licensed as an acute care Facility or a psychiatric unit in a medical Facility that is licensed as an acute care Facility. Services are provided by or under the supervision of an organized staff of Physicians. Continuous 24-hour nursing services are provided under the supervision of a Registered Nurse.

Pulmonary Rehabilitation — An individualized, supervised physical conditioning program. Occupational Therapists teach you how to pace yourself, conserve energy and simplify tasks. Respiratory Therapists train you in bronchial hygiene, proper use of inhalers and proper breathing.

Radiation Therapy — X-ray, radon, cobalt, betatron, telocobalt and radioactive isotope treatment for malignant diseases and other medical conditions.

Reconstructive Surgery — Reconstructive Surgery improves or restores bodily function to the level experienced before the event that necessitated the Surgery or in the case of a congenital defect, to a level considered normal. Such Surgeries may have a coincidental Cosmetic effect.

Registered Nurse (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by appropriate state authority.

Rehabilitation Hospital — An appropriately licensed Facility that provides rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of Physical, Occupational, Speech and Respiratory Therapists, medical social workers and rehabilitation nurses to enable patients

disabled by illness or Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

[**Residential Treatment Center** — See the "Noncovered Providers of Service" exclusion in *General Limitations and Exclusions.*]

Respiratory Therapist — A person qualified for employment in the field of respiratory therapy. A Respiratory Therapist assists patients with breathing problems.

Routine Newborn Care — Care of a child immediately following his/her birth that includes:

- routine Hospital nursery services, including alpha-fetoprotein IV screening
- routine medical care in the Hospital after delivery
- pediatrician standby care at a C-section procedure
- services related to circumcision of a male newborn

Routine Patient Care Cost — For purposes of the Cancer Clinical Trial benefit described under "Rehabilitation and Other Therapy" in *Covered Services,* a medical service or treatment that is covered under a health plan that would be covered if you were receiving standard cancer treatment or an FDA-approved drug provided to you during a Cancer Clinical Trial, but only to the extent that the drug is not paid for by the manufacturer, distributor or supplier of the drug. **Note:** For a covered Cancer Clinical Trial, it is not necessary for the FDA to approve the drug for use in treating your particular condition. A Routine Patient Care Cost does **not** include the cost of any investigational drug, device or procedure, the cost of a non-health care service that you must receive as a result of your participation in the Cancer Clinical Trial, costs for managing the research, costs that would not be covered or that would not be rendered if non-investigational treatments were provided or costs paid or not charged for by the trial Providers.

Short-Term Rehabilitation — Occupational, Physical and Speech Therapy techniques that are Medically Necessary to restore and improve lost bodily functions following illness or Accidental Injury. (This does not include Alcoholism or Drug Abuse rehabilitation.)

Skilled Nursing Care — Care that can be provided only by someone with at least the qualifications of a Licensed Practical Nurse (L.P.N.) or Registered Nurse (R.N.).

Skilled Nursing Facility — A Facility or part of a Facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating Facility; *and*
- is primarily engaged in providing Skilled Nursing Care to Inpatients under the supervision of a duly licensed Physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a Registered Nurse; *and*
- does **not** include any Facility that is primarily a rest home, a Facility for the care of the aged or for treatment of Alcoholism, Drug Abuse, Mental Health Disorder, tuberculosis, or for intermediate, custodial or educational care.

Sound Natural Teeth — Teeth that are whole, without impairment, without periodontal or other conditions and not in need of treatment for any reason other than the Accidental Injury are Sound Natural Teeth. Teeth with crowns or restorations (even if required due to a previous injury) are **not** Sound Natural Teeth. Therefore, injury to a restored tooth will not be covered as an accident-related expense. (Your Provider must submit x-rays taken *before* the dental or Surgical Procedure in order for BCBSNM to determine whether the tooth was "sound.")

Special Care Unit — A designated unit that has concentrated facilities, equipment and supportive services to provide an intensive level of care for critically ill patients. Examples of Special Care Units are intensive care unit (ICU), cardiac care unit (CCU), subintensive care unit and isolation room.

Special Medical Foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a Physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health and metabolic homeostasis.

[**Specialty Pharmacy Drugs** — Specialty Pharmacy Drugs must meet at least two of the following criteria: a) they are high in cost, b) they are for use in limited patient populations or indications, c) they are typically self-injected, d) they have limited availability, require special dispensing or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional pharmacy channels, e) complex reimbursement procedures are required and/or f) a considerable portion of the use and costs are frequently generated through office-based medical claims.]

[**Specialty Pharmacy Provider** — See definition of Participating Pharmacy.]

Speech Therapist — A speech pathologist certified by the American Speech and Hearing Association. A Speech Therapist assists patients in overcoming speech disorders.

Speech Therapy — Services used for the diagnosis and treatment of speech and language disorders.

Subscriber — The person whose employment or other status, except for family dependency, is the basis for enrollment eligibility or in the case of a direct-pay contract, the person in whose name the contract is issued. Subscriber may also encompass other persons in a nonemployee relationship with the employer, Group or business if specified in the Group Master Contract (e.g., COBRA members).

Surgical Services, Surgical Procedures, Surgery — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or Accidental Injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for Surgical Services also include usual and related local anesthesia, necessary assistant surgeon expenses and pre- and post-operative care, including recasting.

Temporomandibular Joint (TMJ) Syndrome — A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints and limitation of jaw movement.

Terminally Ill Patient — A patient with a life expectancy of **6 months or less**, as certified in writing by the attending Physician.

Tertiary Care Facility — A Hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth) and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This Hospital unit also has responsibilities for coordination of transport, communication and data analysis systems for the geographic area served.

Totally Disabled — A Member (Subscriber or Dependent) who is prevented, solely because of illness or Accidental Injury, from engaging in substantial gainful employment or is incapable of doing most of the normal tasks and activities for that person's age and family status.

Transplant — A surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Transplant-Related Services — Any hospitalizations and medical or Surgical Services related to a covered Transplant or retransplant and any subsequent hospitalizations and medical or Surgical Services related to a covered Transplant or retransplant and received within one year of the Transplant or retransplant.

Urgent Care — Medically Necessary health care services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

Waiting Period — The length of time during which benefits will not be available for Preexisting Conditions.

REIMBURSEMENT PROVISION

If you or one of your covered Dependents incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in this Benefit Booklet, you agree:

- BCBSNM has the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total Covered Charges for Covered Services for which BCBSNM has provided benefits to you or your Dependents.
- BCBSNM is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits BCBSNM provided for that sickness or injury.

BCBSNM shall have the right to first reimbursement out of all funds you, your covered Dependents or your legal representative, are or were able to obtain for the same expenses for which BCBSNM has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that BCBSNM may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
Company Tracking Number:	*HCSC ET BCBSNM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBSNM*		
Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
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Product Name:	*HCSC ET BCBSNM*		
Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 06/03/2008
Comments:
Attachment:
AR_AR Certif of Compliance with Rule 19.pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 06/03/2008
Bypass Reason: No policy is being submitted for this filing.
Comments:

Satisfied -Name: Authorization **Review Status:** Approved-Closed 06/03/2008
Comments:
Attachment:
HCSC Authorization to File.pdf

Satisfied -Name: Readability **Review Status:** Approved-Closed 06/03/2008
Comments:
Attachment:
BCBSNM Readability Certification.pdf

Satisfied -Name: Certification of Benefit Differential **Review Status:** Approved-Closed 06/03/2008
Comments:
Attachment:
AR BCBSNM Certification of Benefit Differential.pdf

Insurer: Health Care Service Corporation, a Mutual Legal Reserve Company

Form Number(s): GB-10-1 HCSC
ETGB-AR-HCSC-07

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Scott Hilgeman

Name

Vice President and Chief Underwriter

Title

May 2, 2008
Date

BlueCross BlueShield of Illinois

NAIC Company Code: 70670

Re: Group Medical Forms

To: All State Insurance Departments

Health Care Service Corporation, a Mutual Legal Reserve Company, which also does business as Blue Cross and Blue Shield of Illinois, Blue Cross Blue Shield of Texas, Blue Cross Blue Shield of Oklahoma and Blue Cross Blue Shield of New Mexico**,** hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance departments for their approval.

Sincerely,

Health Care Service Corporation,
a Mutual Legal Reserve Company

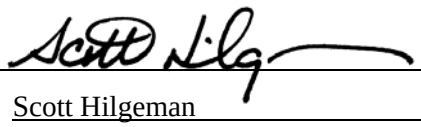
Karen M. Atwood
Senior Vice President
National Accounts

Health Care Service Corporation
300 E. Randolph Street
Chicago, IL 60601

READABILITY CERTIFICATION

To the best of our knowledge and ability we have determined the Flesch scale analysis readability test scores to be as shown:

Form Number	Flesch Score
GB-NM-LT-1 HCSC	42.0
ETGB-AR-HCSC – 07	40.0

By: 

Scott Hilgeman

Title: Vice President and Chief Underwriter

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Health Care Service Corporation

Form Numbers: GB-NM-LT-1 HCSC and ETGB-AR-HCSC-07

I hereby certify that to the best of my knowledge and belief, the above forms and submission comply with Arkansas Insurance Bulletin 9-85, in that the differential of benefits between PPO and non-PPO providers does not exceed 25%.

Scott Hilgeman
Vice President and Chief Underwriter

May 27, 2008
Date

SERFF Tracking Number:	*CMPL-125648906*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39017*
Company Tracking Number:	*HCSC ET BCBSNM*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBSNM*		
Project Name/Number:	*HCSC ET BCBSNM/HCSC ET BCBSNM*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Rider	05/15/2008	HCSC Arkansas ET Rider_rev080907.pdf

RIDER FOR RESIDENTS OF THE STATE OF ARKANSAS

If you reside permanently in the state of Arkansas, the [Certificate][Benefit Booklet] to which this Rider is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the [Certificate][Benefit Booklet] and this Rider, the provisions resulting in greater [benefits][Benefits] will be in effect.

1. **Individual and Family Eligibility**

   The eligibility provision outlining a change in coverage from [individual coverage][Individual Coverage][Single Coverage] to [family coverage][Family Coverage] is changed as follows:

   If you apply for a change from [individual coverage][Individual Coverage][Single Coverage] to [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], your [family coverage][Family Coverage] will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply for [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], you can make application at any time. Your [dependents][Dependents] will be subject to the [preexisting condition waiting period][Preexisting Condition Waiting Period] outlined in the [Certificate][Benefit Booklet] to which this Rider is attached. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

2. **Family Coverage**

   The eligibility provision concerning adding [dependents][Dependents] to [family coverage][Family Coverage] is changed as follows**:**

   If you apply to add your newborn [child][Child] to your [family coverage][Family Coverage] within 90 days of the [child's][Child's] birth or to add your adopted [child][Child] or [child][Child] placed for adoption to your [family coverage][Family Coverage] within 60 days of the adoption or [placement for adoption][Placement for Adoption], coverage for your [dependent][Dependent]will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply to add your newborn within 90 days of the birth, or your adopted [child][Child] within 60 days of the adoption or [placement for adoption][Placement for Adoption], you can make application at any time. Your [dependents][Dependents]will be subject to the [preexisting

condition waiting period][Preexisting Condition Waiting Period] outlined in the [Certificate][Benefit Booklet] to which this Rider is attached. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

3. Providers

Benefits for the following Providers will be paid at the same level as other Providers.

- [Advanced practice nurses][Advanced Practice Nurses].
- Athletic trainers.
- [Audiologists][Licensed Audiologists].
- Certified orthotists.
- [Chiropractors][Doctors of Chiropractic].
- Community mental health centers or clinics.
- [Dentists][Doctors of Dentistry]
- [Coordinated Home Care][Home Health Care][home health care].
- Hospice care.
- Hospital–based service.
- Hospitals.
- Licensed ambulatory surgery centers.
- Licensed [social workers][Clinical Social Workers].
- Licensed [dieticians][Dieticians].
- Licensed [professional counselors][Professional Counselors].
- Licensed psychological examiners.
- Long–term care facilities
- [Occupational therapists][Licensed Occupational Therapists][Occupational Therapists].
- Optometrists.
- Pharmacists.
- [Physical therapists][Licensed Physical Therapists][Physical Therapists].
- Physicians and surgeons (M.D. and D.O.).

- [Podiatrists][Doctors of Podiatry].
- Prostheticists.
- [Psychologists][Doctors of Psychology].
- Respiratory therapists.
- Rural health clinics; and
- [Speech pathologists][Licensed Speech–Language Pathologists].

4. [Speech Therapy

The [speech therapy][Speech Therapy] benefit is revised to delete the [Benefit Period][benefit period] maximum.]

5. Well Child Care

Benefits will be provided for [Eligible Expenses][Eligible Charges][Covered Charges][Allowable Charge] rendered by a Physician to [children][Children] under age 19, even though they are not ill. Benefits will be limited to the following services:

- Immunizations;
- Routine diagnostic tests;
- 20 physical examinations at approximately the following age intervals:
    - Birth,
    - Two weeks,
    - Two months,
    - Four months,
    - Six months,
    - Nine months,
    - 12 months,
    - 15 months,
    - 18 months,
    - Two years,
    - Three years,
    - Four years,
    - Five years,
    - Six years,

- Eight years,
- 10 years,
- 12 years,
- 14 years,
- 16 years, and
- 18 years.

Benefits for immunizations will not be subject to any [copayment][Copayment], [deductible][Deductible], [coinsurance][Coinsurance] or [benefit period][Benefit Period] dollar maximum.

6. Phenylketonuria Treatment

Benefits will be provided for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed by a Physician for the therapeutic treatment of phenylketonuria.

7. Musculoskeletal Disorders

Benefits will be provided for the surgical and non–surgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head including [Temporomandibular Joint Dysfunction][temporomandibular joint disorder][Temporomandibular Joint Syndrome][temporomandibular joint dysfunction] and craniomandibular disorder. Your [benefits][Benefits] for musculoskeletal disorders are the same as your [benefits][Benefits] for any other condition.

8. Speech and Hearing

Benefits will be provided for the treatment of loss or impairment of speech or hearing by a speech pathologist or audiologist subject to the same limits, [deductibles][Deductibles] and [coinsurance][Coinsurance] as other [covered services][Covered Services].

9. In Vitro Fertilization

Benefits will be provided for in vitro fertilization procedures for you or your [dependent][Dependent] spouse when:

- Your or your spouse's oocytes are fertilized with the sperm of you or your spouse, and
- You or your spouse have a history of unexplained infertility of at least two years duration; or
- The infertility is associated with one or more of the following medical conditions:
    - Endometriosis;

- Exposure in utero to diethylstilbestrol, commonly known as DES;
- Blockage of or removal of one or both fallopian tubes that is not a result of voluntary sterilization; or
- Abnormal male factors contributing to the infertility.

- The in vitro fertilization procedures are performed at a [facility][Facility] licensed or certified by the Arkansas Department of Health which conforms to the standards of the American College of Obstetricians and Gynecologists', or are performed at a [facility][Facility] certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
- You or your spouse has been unable to obtain successful pregnancy through any less costly infertility treatment for which coverage is available under the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan].

The [benefits][Benefits] for in vitro fertilization are the same as the [benefits][Benefits] provided under maternity benefit provisions. Cryopreservation, the procedure whereby embryos are frozen for late implantation, is included as an in vitro fertilization procedure.

10. Maternity Care

The coverage for [Maternity Services][Maternity Care][maternity care] is changed to allow [routine nursery care][Routine Nursery Care] and pediatric charges for a well newborn [child][Child] for up to five full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth.

11. Cancer Treatment

Benefits will be provided for drugs used for the treatment of cancer if:

- The drug has been approved by the federal Food and Drug Administration for the treatment of the specific type of cancer for which it has been prescribed; and
- The drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.

12. Mammograms

Benefits will be provided for mammograms as follows:

- A base line mammogram for a female who is at least thirty–five years of age but less than forty years of age;
- One mammogram every one to two years for a female who is from 40 to 49 years of age; and

- One mammogram a year for a female who is at least fifty years of age; or
- A mammogram upon recommendation of a woman's Physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer.

13. Colorectal Cancer

Benefits will be provided for colorectal cancer examinations as follows:

- If you are more than 50 years of age;
- If you are age 50 and under and are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines; or
- If you are experiencing bleeding from the rectum or blood in the stool, or if you have a change in bowel habits such as diarrhea, constipation or narrowing of the stool that lasts for more than five days.

14. Anesthesia and Dental Procedures

Benefits will be provided for anesthesia, [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] charges for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the patient is:

- A [child][Child] under seven years of age who is determined by two licensed [dentists][Dentists] to require without delay necessary dental treatment in a [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] for a significantly complex dental condition;
- A person with a diagnosed serious physical condition or [Mental Illness][Mental Health Care disorder][Mental Health Disorder]; or
- A person with a significant behavioral problem as determined by the [member's][Member's] Physician.

Immunizations are exempt from any [copayment][Copayment], [coinsurance][Coinsurance], deductible[Deductible] or dollar limit.

15. [Mental Illness][Mental Health Care][Mental Health] and [Substance Abuse Rehabilitation][Chemical Dependency][Drug Abuse and Alcoholism]

The benefit maximums for the [inpatient][Inpatient] and [outpatient][Outpatient] treatment of [Mental Illness][Mental Health Care][Mental Health Disorders] do not apply.

Your [benefits][Benefits] for [inpatient][Inpatient] and [outpatient][Outpatient] [Substance Abuse Rehabilitation][treatment of Chemical Dependency][treatment of drug abuse and alcoholism] are limited to a combined maximum of $6,000 each 24 month period. No more than $3,000 shall be provided in any 30 consecutive day period.

A combined lifetime maximum of $12,000 will apply to [benefits][Benefits] for [inpatient][Inpatient] and [outpatient][Outpatient] [Substance Abuse Rehabilitation][treatment of Chemical Dependency][treatment of drug abuse and alcoholism].

16. Late Claim Payments

The interest rate for a [claim][Claim] not paid on time by the claim administrator is 12%.

17. Continuation of Coverage

If you have been insured continuously under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] for at least three months and your coverage has been terminated for any reason other than nonpayment of the required contribution, you may continue coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] for an additional three months. You must request continuation in writing no later than 10 days after the termination of employment or membership or a change in marital status. You must pay the entire premium including any portion paid by your former [employer][Employer]. Continuation of coverage is subject to the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] or a successor [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] remaining in force.

Continuation of coverage shall end at the earliest of the following dates:

- 120 days after continuation of coverage begins;
- The end of the period for which the individual made a timely contribution;
- The contribution due date following the date the individual becomes eligible for Medicare; or
- The date on which the [policy][contract] is terminated or the [group][Group] withdraws from the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan].

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the [Certificate][Benefit Booklet] to which this Rider is attached will remain in full force and effect.

[Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)
(Blue Cross and Blue Shield of Texas)
(Blue Cross and Blue Shield of New Mexico)
(Blue Cross and Blue Shield of Oklahoma)

Raymond F. McCaskey
President

Thomas C. Lubben
Secretary]